DEPARTMENT OF DEFENSE
PUBLICATION SYSTEM

CHANGE TRANSMITTAL

OFFICE OF THE SECRETARY OF DEFENSE
Assistant Secretary of Defense (Health Affairs)

CHANGE NO. 6
to July 1991, Reprint
DoD 6010.8-R
June 24, 1994

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

The Acting Assistant Secretary of Defense (Health Affairs) has authorized the page changes to DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1991 (Reprint).

PAGE CHANGES

Remove: 2-i through 2-iv, 2-3&2-4, 2-9&2-10, 2-17&2-18, 2-20a through 2-26, 4-i through 4-viii, 4-1 through 4-6b, 4-9b&4-10, 4-13d&4-14, 4-17&4-18, 4-21 through 4-24, 4-44 through 4-47, 4-50&4-51, 5-i&5-ii, 5-1&5-2, 6-i&6-ii, 6-3&6-4, 6-23 through 6-24, 6-27 through 6-31, 7-i&7-ii, 7-11 through 7-14, 14-i through 14-2, 14-18&14-18a, 14-21 through 14-26, 15-i through 15-6, and 16-i through 16-2

Insert: Attached replacement pages and new pages 2-v, 4-ix, 4-4a&4-4b, 4-51a&4-51b, 6-3a, 6-3b, 6-32, 6-33, 14-18b&14-18c, 14-27&14-28, 15-ii, 15-7 through 15-10, and 16-3

Changes appear on pages 2-i through 2-v, 2-4, 2-10, 2-17&2-18, 2-21, 2-22, 2-24, 2-25, 4-i, 4-iv, 4-vii, 4-2 through 4-4a, 4-5 through 4-6a, 4-9b, 4-14, 4-18, 4-22, 4-23, 4-45 through 4-46b, 4-50, 5-i, 5-2, 6-i&6-ii, 6-3 through 6-4, 6-23 through 6-24, 6-28 through 6-33, 7-ii, 7-11 through 7-13, 14-i, 14-1, 14-18, 14-18a, 14-21 through 14-24, 14-26, 15-i, 15-1 through 15-4, 15-7 through 15-9, and 16-i through 16-3 and are indicated by marginal bars.

EFFECTIVE DATE

The above changes are effective for services or supplies delivered on or after (1) November 5, 1990 for Coverage of Screening Mammography and Papanicolaou (PAP) Tests; (2) November 1, 1993 for Reimbursement of Providers, Claims Filing, and Participating Provider Program; (3) December 6, 1993 for Specialized Treatment Services, Nonavailability Statements, Peer Review Organization Program, and

THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

NUMBER	DATE	DEPARTMENT OF DEFENSE
6010.8-R, Change 6	June 24, 1994	PUBLICATIONS SYSTEMS TRANSMITTAL

INSTRUCTIONS FOR RECIPIENTS (continued)

Supplemental Care; (4) March 24, 1994 for Requirements for Coverage and Reimbursement of Services of Physicians in Teaching Settings; (5) October 1, 1994 for Delay of Grace Period for Partial Hospitalization Program; and (6) May 22, 1995 for Certified Marriage and Family Therapists.

James L Elmer

JAMES L. ELMER
Director
Correspondence and Directives

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CHAPTER 2

DEFINITIONS

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Admission. The formal acceptance by a CHAMPUS authorized institutional provider of a CHAMPUS beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.

Adopted Child. A child taken into one's own family by legal process and treated as one's own child. In case of adoption, CHAMPUS eligibility begins as of 12:01 a.m. of the day of the final adoption decree. NOTE: There is no CHAMPUS benefit entitlement during any interim waiting period.

All-Inclusive Per Diem Rate. The OCHAMPUS determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient, and accepted by OCHAMPUS.

Allowable Charge. The CHAMPUS-determined level of payment to physicians, other individual professional providers and other providers, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable charge also may be referred to as the CHAMPUS-determined reasonable charge.

Allowable Cost. The CHAMPUS-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods set forth in Chapter 14 of this Regulation. Allowable cost may also be referred to as the CHAMPUS-determined reasonable cost.

Ambulance. A specially designed vehicle for transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such lifesaving equipment required by state and local law, and that is staffed by personnel trained to provide first aid treatment.

Amount in Dispute. The amount of money, determined under this Regulation, that CHAMPUS would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See Chapter 10 for additional information concerning the determination of "amount in dispute" under this Regulation.

Anesthesia Services. The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery or obstetrical care, or shock therapy. Anesthesia services do not include hypnosis or acupuncture.

Appealable Issue. Disputed questions of fact which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS benefits, or approval as an authorized provider in accordance with this Regulation. An appealable issue does not exist if no facts are in dispute, if no CHAMPUS benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. See Chapter 10 for additional information concerning the determination of "appealable issue" under this Regulation.

Appealing Party. Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of this Regulation.

Appropriate Medical Care

1. Services performed in connection with the diagnosis or treatment of disease

or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards; and

3. The services are furnished economically. For purposes of this Regulation, "economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by CHAMPUS.

Approved Teaching Programs. For purposes of CHAMPUS, an approved teaching program is a program of graduate medical education which has been duly approved in its respective speciality or subspecialty by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatry Education of the American Podiatry Association.

Assistant Secretary of Defense (Health Affairs). An authority of the Assistant Secretary of Defense (Health Affairs) includes any person designated by the Assistant Secretary to exercise the authority involved.

Attending Physician. The physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant, or an assistant surgeon, for example would not be an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time. An attending physician also may be a teaching physician.

Authorized Provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under CHAMPUS in Chapter 6 of this Regulation.

Backup Hospital. A hospital which is otherwise eligible as a CHAMPUS institutional provider and which is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of CHAMPUS authorized freestanding institutional provider and which is accessible from the site of the CHAMPUS authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.

Balance billing. A provider seeking any payment, other than any payment relating to applicable and cost-sharing amounts, from a beneficiary for CHAMPUS covered services for any amount in excess of the applicable CHAMPUS allowable cost or charge.

Basic Program. The primary medical benefits authorized under Chapter 55 of title 10, United States Code, and set forth in Chapter 4 of this Regulation.

Beneficiary. An individual who has been determined to be eligible for CHAMPUS benefits, as set forth in Chapter 3 of this Regulation.

specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N.

NOTE: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under CHAMPUS. A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

Days. Calendar days.

Deceased Service Member. A person who, at the time of his or her death, was an active duty member of a Uniformed Service under a call or order that did not specify a period of 30 days or less; or a retiree of a Uniformed Service.

Deductible. Payment by a beneficiary of the first $50 of the CHAMPUS-determined allowable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year; or for a family, the aggregate payment by two or more beneficiaries who submit claims of the first $100.

Deductible Certificate. A statement issued to the beneficiary (or sponsor) by a CHAMPUS fiscal intermediary certifying to deductible amounts satisfied by a CHAMPUS beneficiary for any applicable fiscal year.

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

1. Enrolling all active duty and retired service members, their depen- dents, and the dependents of deceased service members, and

2. Verifying their eligibility for health care benefits in the direct care facilities and through CHAMPUS.

Dental Care. Services relating to the teeth and their supporting structures.

Dentist. Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Dependent. A person who bears any of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less), retiree, or deceased active duty member or retiree, of a Uniformed Service, that is, lawful spouse, former spouse (in certain circum- stances), unremarried widow or widower, or child; or a spouse and child of an active duty member of the armed forces of foreign North Atlantic Treaty Organization (NATO) nations (refer to section B. in Chapter 3 of this Regulation).

Deserter or Desertion Status. A service member is a deserter, or in a desertion status, when the Uniformed Service concerned has made an administrative determination to that effect, or the member's period of unauthorized absence has resulted in a court-martial conviction of desertion. Administrative declarations of desertion normally are made when a member has been an unauthorized absentee for over 30 days, but particular circumstances may result in an earlier declaration. Entitlement to CHAMPUS benefits ceases as of 12:01 a.m. on the day following the day the desertion status is declared. Benefits are not to be authorized for treatment received during a period of unauthorized absence that results in a court-martial conviction for desertion. Dependent eligibility for benefits is reestablished when a deserter is returned to military control and continues, even though the member may be in confinement, until any discharge is executed. When a deserter status is later found to have been determined erroneously, the status of deserter is considered never to have existed, and the member's dependents will have been eligible continuously for benefits under CHAMPUS.

Diagnosis-Related Groups (DRGs). Diagnosis-related groups (DRGs) are a method of dividing hospital patients into clinically coherent groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status.

Diagnostic Admission. An admission to a hospital or other authorized institutional provider, or an extension of a stay in such a facility, primarily for the purpose of performing diagnostic tests, examinations, and procedures.

Director, OCHAMPUS. An authority of the Director, OCHAMPUS includes any person designated by the Director, OCHAMPUS to exercise the authority involved.

Doctor of Dental Medicine (D.M.D.). A person who has received a degree in dentistry, that is, that department of the healing arts which is concerned with the teeth, oral cavity, and associated structures.

#Second Amendment (Ch 6, 6/24/94)

required); prognosis; problem list; and all inclusive current or anticipated monthly charges related to the proposed management plan. If the management plan involves the transfer of a beneficiary from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the management plan documentation.

Marriage and Family Therapist, Certified. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Maternity Care. Care and treatment related to conception, delivery, and abortion, including prenatal and postnatal care (generally through the 6th post-delivery week), and also including treatment of the complications of pregnancy.

Medicaid. Those medical benefits authorized under Title XIX of the Social Security Act (reference (h)) provided to welfare recipients and the medically indigent through programs administered by the various states.

Medical. The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of CHAMPUS, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

Medical Emergency. The sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director, OCHAMPUS, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however, qualify a maternity case as an emergency, nor would incipient birth after the 34th week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

Medically or Psychologically Necessary. The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

#First Amendment (Ch 6, 6/24/94)

Medical Supplies and Dressings (Consumables). Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under CHAMPUS, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

Medicare. Those medical benefits authorized under Title XVIII of the Social Security Act (reference (h)) provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Health Care Financing Administration, Medicare Bureau.

Mental Disorder. For purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III.

Mental Health Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of this Regulation.

Mental Health Therapeutic Absence. A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

Mental Retardation. Subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of moderate and severe mental retardation relates to intelligence quotient (IQ) as follows:

1. Moderate. Moderate mental retardation IQ 36-51.
2. Severe. Severe mental retardation IQ 35 and under.

Missing in Action (MIA). A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence. NOTE: Claims for eligible CHAMPUS beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

Morbid Obesity. The body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the

per day, 5 days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary. Such programs must enter into a participation agreement with CHAMPUS, and be accredited and in substantial compliance with the standards of the Mental Health Manual of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly known as the Consolidated Standards).

Participating Provider. A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished services or supplies to a CHAMPUS beneficiary and that submits a CHAMPUS claim form and accepts assignment of the CHAMPUS determined allowable cost or charge as the total payment(even though less than the actual charge), whether paid for fully by the CHAMPUS allowable amount or requiring cost-sharing by the beneficiary (or sponsor). See Chapter 6.A.8. for more information on the Participating Provider.

Party to a Hearing. An appealing party or parties and CHAMPUS.

Party to the Initial Determination. Includes CHAMPUS and also refers to a CHAMPUS beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized CHAMPUS provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under CHAMPUS, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See Chapter 10 for additional information concerning parties not entitled to administrative review under the CHAMPUS appeals and hearing procedures.

Pastoral Counselor. An extramedical individual provider who meets the requirements outlined in Chapter 6 of the Regulation.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Physical Medicine Services or Physiatry Services. The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

Physical Handicap. A physical condition of the body that meets the following criteria:

1. Duration. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and

2. Extent. The condition is of such severity as to preclude the individual from engaging in substantially basic productive activities of daily living expected of unimpaired persons of the same age group.

Physical Therapist. A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultra- sound), who has been authorized legally (that is, registered) to administer reatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

Physician. A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

Physician in Training. Interns, residents, and fellows participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital or other institutional provider setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

Podiatrist (Doctor of Podiatry or Surgical Chiropody). A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

Preauthorization. A decision issued in writing by the Director, OCHAMPUS, or a designee, that CHAMPUS benefits are payable for certain services that a beneficiary has not yet received.

Prescription Drugs and Medicines. Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration, and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under CHAMPUS as if FDA approved.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

Preventive Care. Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

Primary Payer. The plan or program whose medical benefits are payable first in a double coverage situation.

Private Duty (Special) Nursing Services. Skilled nursing services ren- dered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (R.N.) or licensed practical or vocational nurse (L.P.N. or L.V.N.) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

Private Room. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

Program for the Handicapped (PFTH). The special program set forth in Chapter 5 of this Regulation, through which dependents of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically handicapped over and above those medical benefits available under the Basic Program.

Progress notes. Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; a notation of the patient's signs and symptoms; the issues, pathology and specific behaviors addressed in the therapy session; a statement summarizing the therapeutic interventions attempted during the therapy session; descriptions of the response to treatment, the outcome of the treatment, and the response to significant others; and a statement summarizing the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered.

Prosthetic Device (Prosthesis). An artificial substitute for a missing body part.

Provider. A hospital or other institutional provider, a physician, or other individual professional provider, or other provider of services or supplies as specified in Chapter 6 of this Regulation.

Provider Exclusion and Suspension. The terms "exclusion" and "suspension", when referring to a provider under CHAMPUS, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under CHAMPUS. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized CHAMPUS provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under CHAMPUS, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of the CHAMPUS or CHAMPUS beneficiaries to exclude or suspend the provider.

Provider Termination. When a provider's status as an authorized CHAMPUS provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in Chapter 6 of this Regulation, to be an authorized CHAMPUS provider.

Psychiatric Emergency. A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

Radiation Therapy Services. The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

Referral. The act or an instance of referring a CHAMPUS beneficiary to another authorized provider to obtain necessary medical treatment. Under CHAMPUS, only a physician may make referrals.

#Third Amendment (Ch 5, 9/17/93)

Registered Nurse. A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is regis- tered for practice after examination by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

Representative. Any person who has been appointed by a party to the ini- tial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Resident (Medical). A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

Residential Treatment Center (RTC). A facility (or distinct part of a facility) which meets the criteria in Chapter 6.B.4.

Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Routine Eye Examinations. The services rendered in order to determine the refractive state of the eyes.

Sanction. For purpose of Chapter 9, "sanction" means a provider exclusion, suspension, or termination.

Secondary Payer. The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Semiprivate Room. A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of CHAMPUS.

Skilled Nursing Facility. An institution (or a distinct part of an institution) that meets the criteria as set forth in subsection B.4. of Chapter 6 of this Regulation.

Skilled Nursing Service. A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Specialized Treatment Service Facility. A military or civilian medical treatment facility specifically designated pursuant to Chapter 4, paragraph A.10, to be a referral facility for certain highly specialized care. For this purpose, a civilian medical treatment facility may be another federal facility (such as a Department of Veterans Affairs hospital).

Special Tutoring. Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

Spectacles, Eyeglasses, and Lenses. Lenses, including contact lenses, that help to correct faulty vision.

Sponsor. An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her dependents' eligibility for CHAMPUS is based.

Spouse. A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Student Status. A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Suppliers of Portable X-Ray Services. A supplier that meets the condi- tions of coverage of the Medicare program, set forth in the Medicare regu- lations (reference (m)), or the Medicaid program in the state in which the covered service is provided.

Surgery. Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in paragraph C.2.a. of Chapter 4 of this Regulation.

Surgical Assistant. A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

Suspension of Claims Processing. The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific CHAMPUS beneficiary pending action by the Director, OCHAMPUS, or a designee, in a case of suspected fraud or abuse. The action may include the administrative remedies provided for in Chapter 9 or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by OCHAMPUS, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

Teaching Physician. A teaching physician is any physician whose duties include providing medical training to physicians in training within a hospital or other institutional provider setting.

Timely Filing. The filing of CHAMPUS claims within the prescribed time limits as set forth in Chapter 7 of this Regulation.

Treatment Plan. A detailed description of the medical care being rendered or expected to be rendered a CHAMPUS beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in section B. of Chapter 4 of this Regulation. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a CHAMPUS patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Uniformed Services. The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Veteran. A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her dependents are eligible for benefits under CHAMPUS.

Well-Baby Care. A specific program of periodic health screening, developmental assessment, and routine immunization for children from birth up to 2 years.

Widow or Widower. A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Worker's Compensation Benefits. Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-Ray Services. An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.

CHAPTER 4

BASIC PROGRAM BENEFITS

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CHAPTER 4
BASIC PROGRAM BENEFITS

A. GENERAL

The CHAMPUS Basic Program is essentially a supplemental program to the Uniformed Services direct medical care system. The Basic Program is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

2. Persons eligible for Basic Program benefits. Persons eligible to receive the Basic Program benefits are set forth in Chapter 3 of this Regulation. Any person determined to be an eligible CHAMPUS beneficiary is eligible for Basic Program benefits.

3. Authority to act for CHAMPUS. The authority to make benefit determinations and authorize the disbursement of funds under CHAMPUS is restricted to the Director, OCHAMPUS; designated OCHAMPUS staff; Director, OCHAMPUSEUR; or CHAMPUS fiscal intermediaries. No other persons or agents (such as physicians, staff members of hospitals, or CHAMPUS health benefits advisors) have such authority.

4. Status of patient controlling for purposes of cost-sharing. Benefits for covered services and supplies described in this chapter will be extended either on an inpatient or outpatient cost-sharing basis in accordance with the status of the patient at the time the covered services and supplies were provided, unless otherwise specifically designated (such as for ambulance service or maternity care). For cost-sharing provisions, refer to section F. of this chapter.

5. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or its CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for preauthorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determina-

tion, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions, or (c) disclosure is authorized or required specifically under the terms of the Privacy Act or Freedom of Information Act (references (i) through (k)) (refer to section M. of chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries may release, without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use published in the Federal Register in accordance with DoD 5400.11-R (reference (k)). Before a person's claim of benefits will be adjudicated, the person must furnish to CHAMPUS information that reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

6. Physical examinations. The Director, OCHAMPUS, or a designee, may require a beneficiary to submit to one or more medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized medically necessary services and supplies required in the diagnosis or treatment of an illness or injury (including maternity and well-baby care). When a medical examination has been requested, CHAMPUS will withhold payment of any pending claims or preauthorization requests on that particular beneficiary. If the beneficiary refuses to agree to the requested medical examination, or unless prevented by a medical reason acceptable to OCHAMPUS, the examination is not performed within 90 days of initial request, all pending claims for services and supplies will be denied. A denial of payments for services or supplies provided before (and related to) the request for a physical examination is not subject to reconsideration. The medical examination and required beneficiary travel related to performing the requested medical examination will be at the expense of CHAMPUS. The medical examination may be performed by a physician in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee who is responsible for making such arrangements as are necessary, including necessary travel arrangements.

7. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits, must, except as provided in Chapter 7, of this regulation, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within the deadline waives all rights to benefits for such services or supplies.

8. Double coverage and third party recoveries. CHAMPUS claims involving double coverage or the possibility that the United States can recover all or a part of its expenses from a third party, are specifically subject to the provisions of Chapter 8 or Chapter 12 of this Regulation as appropriate.

9. Nonavailability Statements within a 40-mile catchment area. In some geographic locations (or under certain special circumstances), it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Service facility. If the required medical care cannot be provided, the hospital commander, or a designee, will issue a Nonavailability Statement (DD Form 1251). Except for emergencies, a Nonavailability Statement should be issued before medical care is obtained from a civilian source. Failure to secure such a statement may waive the beneficiary's rights to benefits under CHAMPUS.

a. Rules applicable to issuance of Nonavailability Statement (DD Form 1251).

(1) The ASD(HA) is responsible for issuing rules and regulations regarding Nonavailability Statements.

(2) A Nonavailability Statement (NAS) is required for services in connection with nonemergency inpatient hospital care if such services are available at a facility of the Uniformed Services located within a 40-mile radius of the residence of the beneficiary, except that a NAS is not required for services otherwise available at a facility of the Uniformed Services located within a 40-mile radius of the beneficiary's residence when another insurance plan or program provides the beneficiary primary coverage for the services.

(3) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (excluding facilities which are exclusively outpatient clinics) located within a 40-mile radius (catchment area) of the residence of the beneficiary. This does not apply to emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published in the Federal Register at least 30 days before the effective date of the change by the ASD(HA) and will be limited to the following categories: outpatient surgery and other selected outpatient procedures which have high unit costs and for which care may be available in military treatment facilities generally. The selected outpatient procedures will be uniform for all CHAMPUS beneficiaries.

(4) In addition to NAS requirements set forth in paragraph A.9, of this chapter, additional NAS requirements are established pursuant to paragraph A.10, of this chapter in connection with highly specialized care in national or 200 mile catchment areas of military or civilian Specialized Treatment Services Facilities.

b. Beneficiary responsibility. The beneficiary is responsible for securing information whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules and regulations may be obtained from the Offices of the Army, Navy, and Air Force Surgeon Generals; or a CHAMPUS health benefits advisor; or the Director, OCHAMPUS, or a designee; or from the appropriate CHAMPUS fiscal intermediary.

c. Rules in effect at time civilian medical care is provided apply. The applicable rules and regulations regarding Nonavailability Statements in effect at the time the civilian care is rendered apply in determining whether a Nonavailability Statement is required.

d. Nonavailability Statement (DD Form 1251) must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement was issued, a valid Nonavailability Statement authorization must be on DEERS.

e. Nonavailability Statement (NAS) and claims adjudication.

(1) A NAS is valid for the adjudication of CHAMPUS claims for all related care otherwise authorized by this Regulation which is received from a civilian source while the beneficiary resided within the Uniformed Service facility catchment area which issued the NAS.

(2) A requirement for a NAS for inpatient hospital maternity care must be met for CHAMPUS cost-share of any related outpatient maternity care.

10. Nonavailability Statements in national or 200-mile catchment areas for highly specialized care available in selected military or civilian Specialized Treatment Service Facilities.

a. Specialized Treatment Service Facilities. STS Facilities may be designated for certain high cost, high technology procedures. The purpose of such designations is to concentrate patient referrals for certain highly specialized procedures which are of relatively low incidence and/or relatively high per case cost and which require patient concentration to permit resource investment and enhance the effectiveness of quality assurance efforts.

b. Designation. Selected military treatment facilities and civilian facilities will be designated by the Assistant Secretary of Defense for Health Affairs as STS Facilities for certain procedures. These designations will be based on the highly specialized capabilities of these selected facilities. For each STS designation for which NASs in national or 200-mile catchment areas will be required, there shall be a determination that total government costs associated with providing the service under the Specialized Treatment Services program will in aggregate be less than the total government cost of that service under the normal operation of CHAMPUS. There shall also be a determination that the Specialized Treatment Services Facility meets a standard of excellence in quality comparable to that prevailing in other specialized medical centers in the nation or region
that provide the services involved.

c. Organ transplants and similar procedures. For organ transplants and procedures of similar extraordinary specialization, military or civilian STS Facilities may be designated for a nationwide catchment area, covering all 50 states, the District of Columbia and Puerto Rico (or, alternatively, for any portion of such a nationwide area).

d. Other highly specialized procedures. For other highly specialized procedures, military or civilian STS Facilities will be designated for catchment areas of up to approximately 200 miles radius. The exact geographical area covered for each STS Facility will be identified by reference to State and local

governmental jurisdictions, zip code groups or other method to describe an area within an approximate radius of 200 miles from the facility. In paragraph A.10 of this chapter, this catchment area is referred to as a "200-mile catchment area".

e. NAS requirement. For procedures subject to a nationwide catchment area NAS requirement under paragraph A.10.c of this chapter or a 200-mile catchment area NAS requirement under paragraph A.10.d of this chapter CHAMPUS cost sharing is not allowed unless the services are obtained from a designated civilian Specialized Treatment Services program (as authorized) or an NAS has been issued. This rule is subject to the exception set forth in paragraph A.10.f of this chapter. This NAS requirement is a general requirement of the CHAMPUS program.

f. Exceptions. Nationwide catchment area NASs and 200-mile catchment area NASs are not required in any of the following circumstances:

(1) An emergency.

(2) When another insurance plan or program provides the beneficiary primary coverage for the services.

(3) A case-by-case waiver is granted based on a medical judgment made by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, it would be medically inappropriate because of a delay in the treatment or other special reason to require that the STS Facility be used; or

(4) A case-by-case waiver is granted by the commander of the STS Facility (or other person designated for this purpose) that, although the care is available at the facility, use of the facility would impose exceptional hardship on the beneficiary or the beneficiary's family.

g. Waiver process. A process shall be established for beneficiaries to request a case-by-case waiver under paragraphs A.10.f.(3)(4) of this chapter. This process shall include:

(1) An opportunity for the beneficiary (and/or the beneficiary's physician) to submit information the beneficiary believes justifies a waiver.

(2) A written decision from a person designated for the purpose on the request for a waiver, including a statement of the reasons for the decision.

(3) An opportunity for the beneficiary to appeal an unfavorable decision to a designated appeal authority not involved in the initial decision; and

(4) A written decision on the appeal, including a statement of the reasons for the decision.

h. Notice. The Assistant Secretary of Defense for Health Affairs will annually publish in the Federal Register a notice of all military and civilian STS Facilities, including a listing of the several procedures subject to nationwide catchment area NASs and the highly specialized procedures subject to 200-mile catchment area NASs.

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i. Specialized procedures. Highly specialized procedures that may be established as subject to 200-mile catchment area NASs are limited to:

(1) Medical and surgical diagnoses requiring inpatient hospital treatment of an unusually intensive nature, documented by a DRG-based payment system weight (pursuant to Chapter 14, paragraph A.1) for a single DRG or an aggregated DRG weight for a category of DRGs of at least 2.0 (i.e., treatment is at least two times as intensive as the average CHAMPUS inpatient case).

(2) Diagnostic or therapeutic services, including outpatient services, related to such inpatient categories of treatment.

(3) Other procedures which require highly specialized equipment the cost of which exceeds $1,000,000 (e.g., lithotriptor, positron emission tomography equipment) and such equipment is underutilized in the area; and

(4) Other comparable highly specialized procedures as determined by the Assistant Secretary of Defense for Health Affairs.

j. Quality standards. Any facility designated as a military or civilian STS Facility under paragraph A.10 of this chapter shall be required to meet quality standards established by the Assistant Secretary of Defense for Health Affairs. In the development of such standards, the Assistant Secretary shall consult with relevant medical speciality societies and other appropriate parties. To the extent feasible, quality standards shall be based on nationally recognized standards.

k. NAS procedures. The provisions of paragraphs A.9.b through A.9.e of this chapter regarding procedures applicable to NASs shall apply to expanded catchment area NASs required by paragraph A.10 of this chapter.

l. Travel and lodging expenses. In accordance with guidelines issued by the Assistant Secretary of Defense for Health Affairs, certain travel and lodging expenses associated with services under the Specialized Treatment Services program may be fully or partially reimbursed.

m. Preference for military facility use. In any case in which services subject to an NAS requirement under paragraph A.10 of this chapter are available in both a military STS Facility and from a civilian STS Facility, the military Facility must be used unless use of the civilian Facility is specifically authorized.

11. Quality and Utilization Review Peer Review Organization program. All benefits under the CHAMPUS program are subject to review under the CHAMPUS Quality and Utilization Review Peer Review Organization program pursuant to Chapter 15. Utilization and quality review of mental health services are also part of the Peer Review Organization program, and are addressed in paragraph A.12 of this chapter.)

12. Utilization review, quality assurance and preauthorization for inpatient mental health services.

a. In general. The Director, OCHAMPUS shall provide, either directly or through contract, a program of utilization and quality review for all mental health care services. Among other things, this program shall include mandatory

preadmission authorization before nonemergency inpatient mental health services may be provided and mandatory approval of continuation of inpatient services within 72 hours of emergency admissions. This program shall also include requirements for other pretreatment authorization procedures, concurrent review of continuing inpatient and partial hospitalization care, retrospective review, and other such procedures as determined appropriate by the Director, OCHAMPUS. The provisions of paragraph H of this chapter and paragraph F, Chapter 15, shall apply to this program. The Director, OCHAMPUS, shall establish, pursuant to paragraph F., Chapter 15, procedures substantially comparable to requirements of paragraph H of this chapter and Chapter 15. If the utilization and quality review program for mental health care services is provided by contract, the contractor(s) need not be the same contractor(s) as are engaged under Chapter 15 in connection with the review of other services.

b. Preadmission authorization.

(1) This section generally requires preadmission authorization for all nonemergency inpatient mental health services and prompt continued stay authorization after emergency admissions. It also requires preadmission authorization for all admissions to a partial hospitalization program, without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Institutional services for which payment would otherwise be authorized, but which were provided without compliance with preadmission authorization requirements, do not qualify for the same payment that would be provided if the preadmission requirements had been met.

(2) In cases of noncompliance with preauthorization requirements, a payment reduction shall be made in accordance with Chapter 15, paragraph B.4.c.

(3) For purposes of paragraph A.12.b.(2) of this chapter, a day of services without the appropriate preauthorization is any day of services provided prior to:

(a) the receipt of an authorization; or

(b) the effective date of an authorization subsequently received.

(4) Services for which payment is disallowed under paragraph A.12.b.(2) of this chapter may not be billed to the patient (or the patient's family).

13. Implementing instructions. The Director, OCHAMPUS, shall issue policies, procedures, instructions, guidelines, standards, and/or criteria to implement this chapter.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an

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OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. Depending on the individual circumstances, teaching physician services may be considered an institutional benefit in accordance with this Section or a professional benefit under Section C. See paragraph C.3.m. of the Chapter for the CHAMPUS requirements regarding teaching physicians. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive admissions will be determined separately for maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive set of symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient, appropriate level required. For purposes of inpatient care, the level of institutional care for which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment except for patients requiring skilled nursing facility care. For patients for whom skilled nursing facility care is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility. General locality means an area that includes all the skilled nursing facilities within 50 miles of the higher level facility, unless the higher level facility can demonstrate that the skilled nursing facilities are inaccessible to its patients. The decision as to whether a skilled nursing facility is within the higher level facility's general locality, or the skilled nursing facility is inaccessible to the higher level facility's patients shall be a CHAMPUS contractor initial determination for the purposes of appeal under chapter 10 of this regulation. CHAMPUS institutional benefit payments shall be limited to the

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allowable cost that would have been incurred in the skilled nursing facility, as determined by the Director, OCHAMPUS, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can be extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

(b) A preliminary treatment plan must be established within 24 hours of the admission.

(c) A master treatment plan must be established within ten calendar days of the admission.

(3) The elements of the individualized treatment plan must include:

(a) The diagnostic evaluation that establishes the necessity for the admission;

(b) An assessment regarding the inappropriateness of services at a less intensive level of care;

(c) A comprehensive, biopsychosocial assessment and diagnostic formulation;

(d) A specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;

(e) A specific plan for involvement of family members, unless therapeutically contraindicated; and

(f) A discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

(4) Preauthorization requests should be made not fewer than two business days prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. Pre-authorizations are valid for the period of time, appropriate to the type of care involved, stated when the preauthorization is issued. In general, pre-authorizations are valid for 30 days.

i. Concurrent review. Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. The criteria for concurrent review shall be those set forth in paragraph B.4.g. of this chapter. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active individualized clinical treatment being provided and on developing appropriate discharge plans.

5. Extent of institutional benefits

a. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing

provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as semiprivate for the purpose of CHAMPUS.

(2) Private. A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires isolation; or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost of private accommodations is covered under the circumstances described in subparagraph B.5.a.(2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in subparagraphs B.5.a.(2)(a) and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other

(4) Treatment services. All services, supplies, equipment and space necessary to fulfill the requirements of each patient's individualized diagnosis and treatment plan (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy based upon the provisions of B.10.g. of this chapter.) All mental health services must be provided by a CHAMPUS authorized individual professional provider of mental health services. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.]

g. Social services required. The facility must provide an active social services component which assures the patient appropriate living arrangements after treatment hours, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

h. Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients do not fall behind in educational placement while receiving partial hospital treatment. CHAMPUS will not fund the cost of educational services separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program.

i. Family therapy required. The facility must ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized individual professional provider of mental health services. There is no acceptable substitute for family therapy. An exception to this requirement may be granted on a case-by-case basis by the Director, OCHAMPUS, or designee, only if family therapy is clinically contraindicated.

j. Professional mental health benefits limited. Professional mental health benefits are limited to a maximum of one session (60 minutes individual, 90 minutes family) per authorized treatment day not to exceed five sessions in any calendar week. These may be billed separately from the partial hospitalization per diem rate only when rendered by an attending, CHAMPUS-authorized mental health professional who is not an employee of, or under contract with, the partial hospitalization program for purposes of providing clinical patient care.

k. Non-mental health related medical services. Separate billing will be allowed for otherwise covered, non-mental health related medical services.

C. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusion as may be otherwise set forth

in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. Further, except under specifically defined circumstances, there should be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. For these exceptions, refer to Chapter 6.)

a. Billing practices. To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a fee-for-service basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. See paragraph C.3.m. of this Chapter for the requirements regarding the special circumstances for teaching physicians. For continuing professional care, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. Services must be related. Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. Covered services of physicians and other authorized individual professional providers

a. Surgery. Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

Bronchoscopy
Laryngoscopy
Thoracoscopy
Catheterization of the heart
Arteriograph thoracic lumbar
Esophagoscopy
Gastroscopy
Proctoscopy
Sigmoidoscopy
Peritoneoscopy
Cystoscopy
Colonoscopy
Upper G.I. panendoscopy
Encephalograph
Myelography
Discography
Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

(1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(2) If the surgery was performed by a team of surgeons;

(3) If there were multiple surgical assistants; or

(4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

e. Cast and sutures, removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one individual professional provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialities. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending surgeon. A consultation performed within 3 days of surgery by the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (performed by the same physician), benefits may be extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not payable for anesthesia administered by the attending physician (surgeon or obstetrician) or dentist, or by the surgical, obstetrical, or dental assistant.

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, RTCs, or specialized treatment facilities, as authorized by the Director, OCHAMPUS, or a designee. All such services are subject to review for medical or psychological necessity and for quality of care. The Director, OCHAMPUS, reserves the right to require preauthorization of mental health services. Preauthorization may be conducted by the Director, OCHAMPUS, or a designee. In order to qualify for CHAMPUS mental health benefits, the patient must be diagnosed by a CHAMPUS-authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder," or V codes. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph C.3.i.(1) rendered by an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual psychotherapy session is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychological Association or the American Psychiatric Association and when preauthorized by the Director, OCHAMPUS, or a designee.

#Second Amendment (Ch 6, 6/24/94)

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a private duty (special) nurse to a beneficiary reguiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private duty (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an ICU. In addition, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to be medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a member of the immediate family nor is a member of the beneficiary's household.

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services would not qualify as covered private duty (special) nursing services, regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are

better accommodated through the use of visiting nurses. This allows the personal services that are not coverable by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS.

NOTE: When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a L.P.N. or L.V.N.

m. Physicians in a teaching setting.

(1) Teaching Physicians.

(a) General. The services of teaching physicians may be reimbursed on an allowable charge basis only when the teaching physician has established an attending physician relationship between the teaching physician and the services (e.g., services rendered as a consultant, assistant surgeon, etc.). Attending physician services may include both direct patient care services or direct supervision of care provided by a physician in training. In order to be considered an attending physician, the teaching physician must:

1 Review the patient's history and the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and

2 Personally examine the patient; and

3 Confirm or revise the diagnosis and determine the course of treatment to be followed; and

4 Either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by physicians in training and that the care meets a proper quality level; and

5 Be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and

6 Be personally responsible for the patient's care, at least throughout the period of hospitalization.

(b) Direct supervision by an attending physician of care provided by physicians in training. Payment on the basis of allowable charges may be made for the professional services rendered to a beneficiary by his/her attending physician when the attending physician provides personal and identifiable direction to physicians in training who are participating in the care of the patient. It is not necessary that the attending physician be personally present for all services, but the attending physician must be on the provider's premises and available to provide immediate personal assistance and direction if needed.

(c) Individual, personal services. A teaching physician may be reimbursed on an allowable charge basis for any individual, identifiable service rendered to a CHAMPUS beneficiary, so long as the service is a covered service and is normally reimbursed separately, and so long as the patient records substantiate the service.

(d) Who may bill. The services of a teaching physician must be billed by the institutional provider when the physician is employed by the provider or a related entity or under a contract which provides for payment to the physician by the provider or a related entity. Where the teaching physician has no relationship with the provider (except for standard physician privileges to admit patients) and generally treats patients on a fee-for-service basis in the private sector, the teaching physician may submit claims under his/her own provider number.

(2) Physicians in training. Physicians in training in an approved teaching program are considered to be "students" and may not be reimbursed directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider. Services of physicians in training may be reimbursed on an allowable charge basis only if:

(a) The physician in training is fully licensed to practice medicine by the state in which the services are performed, and

(b) The services are rendered outside the scope and requirements of the approved training program to which the physician in training is assigned.

D. OTHER BENEFITS

1. General. Benefits may be extended for the allowable charge of those other covered services and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described sufficiently, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this Regulation. Except for claims subject to the CHAMPUS DRG-based payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution in connection with covered treatment, benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

(3) Newborn patient in his or her own right. When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn child becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. Outpatient cost-sharing. Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

d. Ambulatory surgery. Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of $25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, OCHAMPUS, or a designee.

e. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

3. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees. CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. The annual fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees, is the same as the annual fiscal year outpatient deductible applicable to dependents of active duty members of rank E-5 or above (refer to paragraph F.2.a.(1) or (2) of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem,

the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d.(2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing.

(1) For services other than ambulatory surgery services. Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter) for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

(2) For services subject to the ambulatory surgery payment method. For services subject to the ambulatory surgery payment method set forth in Chapter 14 D., of this regulation, the cost share shall be the lesser of: 25 percent of the payment amount provided pursuant to Chapter 14.D.; or 25 percent of the center's billed charges.

d. Psychiatric partial hospitalization services. Institutional and professional services provided under the psychiatric partial hospitalization program authorized by paragraph B.10. of this chapter shall be cost-shared as inpatient services.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first $150 of the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. (Except for services received prior to April 1, 1991, the deductible amount is $50.00). The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing. Eligible former spouses are responsible for payment of 25 percent of the CHAMPUS-determined reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, for general requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the responsibility of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined allowable costs or charges are made in accordance with the provisions of Chapter 14. All CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable claim was submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS DRG-based payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE: When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating providers. There are several circumstances under which institutional and individual providers may be Participating Providers, either on a mandatory basis or a voluntary basis. See Chapter 6, A.8. A Participating Provider, whether participating for all claims or on a claim-by-claim basis, must accept the CHAMPUS-determined allowable amount as payment in full for the medical services or supplies provided, and must accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by or on behalf of the beneficiary as payment in full for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the CHAMPUS-determined allowable cost or charge for authorized services or supplies.

b. Nonparticipating providers. Nonparticipating providers are those providers who do not agree on the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services and supplies provided by such

nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary is liable under applicable law for any amounts over the CHAMPUS-determined allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to be covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately reflects the application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general rule; they are not all inclusive.

(1) In the case of services provided by individual health care professionals and other noninstitutional providers, the cost-share shall be the usual percentage of the CHAMPUS allowable charge determined under Chapter 14, section I.

(2) In the case of services provided by institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under Chapter 14, section A.1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced in setting the discount rate.

9. Waiver of deductible amounts or cost-sharing not allowed.

a. General rule. Because deductible amounts and cost sharing are statutorily mandated, except when specifically authorized by law (as determined by the Director, OCHAMPUS), a provider may not waive or forgive beneficiary liability for annual deductible amounts or inpatient or outpatient cost-sharing, as set forth in this chapter.

b. Exception for bad debts. This general rule is not violated in cases in which a provider has made all reasonable attempts to effect collection, without success, and determines in accordance with generally accepted fiscal management standards that the beneficiary liability in a particular case is an uncollectible bad debt.

c. Remedies for noncompliance. Potential remedies for noncompliance with this requirement include:

(1) A claim for services regarding which the provider has waived the beneficiary's liability may be disallowed in full, or, alternatively, the amount payable for such a claim may be reduced by the amount of the beneficiary liability waived.

(2) Repeated noncompliance with this requirement is a basis for exclusion of a provider.

G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated and described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care except as provided in the following paragraph.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms except for cancer screening mammography and cancer screening papanicolaou (PAP) smears provided under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other authorized institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE: If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if performed on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will be computed as if performed on an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences. Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, OCHAMPUS, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs E.12.b., E.12.c. and E.12.d. of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. Costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost or charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made. Services or supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a local, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals serving the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid) (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, or research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

d. Rh immune globulin.

e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

g. Screening mammography for asymptomatic women 35 years of age and older when provided under the terms and conditions contained in the guidelines adopted by the Director OCHAMPUS.

h. Cancer screening papanicolaou (PAP) smear for women who are or have been sexually active, and women 18 years of age and older under the terms and conditions contained in the guidelines adopted by the Director, OCHAMPUS.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition; for example, educational counseling, vocational counseling, nutritional counseling, counseling for socio-economic purposes, diabetic self-education programs, stress management, life style modification, etc. Services provided by a certified marriage and family therapist, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors and certified addiction counselors are covered only when rendered in a CHAMPUS-authorized treatment setting and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic.

41. Hair transplants, wigs, or hairpieces

NOTE: In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (o)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.1.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. In addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as an integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (orthoptics).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness or injury. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. All dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except as specifically provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.

54. Elevators or chair lifts.

55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (such as cotton fabric as against synthetic fabric and vegetable dyed shoes).

57. Food, food substitutes. Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care.

RESERVED

CHAPTER 5

PROGRAM FOR THE HANDICAPPED (PFTH)

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CHAPTER 5
PROGRAM FOR THE HANDICAPPED (PFTH)

A. GENERAL

The PFTH is essentially a program of financial assistance for military personnel on active duty whose spouses or children may be moderately or severely mentally retarded or seriously physically handicapped and in need of specialized institutional care, training, or rehabilitation, and the required services are not available from public institutions or agencies. The PFTH was established by Congress to be a source of financial assistance when an active duty member's handicapped dependents, by virtue of residency laws, have been excluded from appropriate publicly operated programs or institutions for the handicapped. There is, therefore, a requirement that all local resources must be considered and those determined as adequate be utilized first, before an application for coverage under the PFTH will be acted on by the Director, OCHAMPUS, or a designee. There is a further requirement that all institutional care otherwise authorized be provided in not-for-profit CHAMPUS-approved institutions. Coverage for any services or supplies under the PFTH requires prior approval.

1. Physical or mental examinations. The Director, OCHAMPUS, or a designee, may request a beneficiary to submit to one or more appropriate medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized services and supplies required in the proposed management plan for the handicapped dependent. When such an examination has been requested, CHAMPUS will withhold payment of any pending claim or claims or preauthorization requests on that particular beneficiary. If the beneficiary or sponsor does not agree to the requested examination, or unless prevented by a medical reason acceptable to CHAMPUS, the examination is not performed within 90 days of the initial request, all pending claim or claims for services and supplies will be denied. A denial of payments for such services or supplies provided before and related to the request for a physical examination is not subject to reconsideration. The cost of the examination or examinations will be at the
expense of CHAMPUS (including any related beneficiary transportation costs). The examination or examinations may be performed by a physician or physicians in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee, who is responsible for making such arrangements as are necessary.

2. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis of, treatment rendered, or services and supplies furnished to, a beneficiary and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary or sponsor must provide particular additional information relevant to the requested determination, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary;

(b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or (c) disclosure is authorized or required specifically under the terms of the Privacy or Freedom of Information Acts (references (i), (j), and (k)) (refer to section M. of chapter 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to any insurance company or other organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use duly published in the Federal Register in accordance with the Privacy Act (reference (k)). Before a beneficiary's or sponsor's claim of benefits will be adjudicated, the beneficiary or sponsor must furnish to CHAMPUS that information which reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

3. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits must, except as provided in Chapter 7, of this regulation, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within this deadline waives all rights to benefits for such services or supplies.

4. Eligibility for benefits

a. Eligibility criteria. Eligibility criteria for CHAMPUS generally are contained in Chapter 3 of this Regulation. However, coverage under the PFTH includes and is further limited to:

(1) The dependents, as defined in Chapter 3 but excluding former spouses, of a member of one of the Uniformed Services who is under call or order to active duty that does not specify a period of 30 days or less, who are moderately or severely mentally retarded or who have a serious physical handicap; or

(2) The dependents of a deceased active duty service member who died after January 1, 1967, while eligible for receipt of hostile fire pay or from a disease or injury incurred while eligible for such pay, who are under 21 years of age, and who otherwise meet the criteria of subparagraph A.4.a.(1), above, and were receiving benefits under the PFTH at the time of said member's death.

b. Sponsor ceases to be active duty member. When the sponsor ceases to be an active duty member because of death, benefits under the PFTH may be continued through the last day of the calendar month following the month in which the sponsor's death occurred. When the sponsor ceases to be an active duty member for any other reason, such as retirement, separation, or deserter status, benefits under the PFTH cease as of 12:01 a.m. of the day following the day the status of the sponsor changes. Exception is made only for those spouses and children under 21 years of age of deceased members

CHAPTER 6

AUTHORIZED PROVIDERS

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6. Exclusion of beneficiary liability. In connection with certain utilization review, quality assurance and preauthorization requirements of Chapter 4, providers may not hold patients liable for payment for certain services for which CHAMPUS payment is disallowed. With respect to such services, providers may not seek payment from the patient or the patient's family. Any such effort to seek payment is a basis for termination of the provider's authorized status.

7. Provider required. In order to be considered for benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a CHAMPUS-authorized provider practicing within the scope of his or her license.

8. Participating providers.

a. In general. A Participating Provider is an individual or institutional provider that has agreed to accept the CHAMPUS-determined allowable amount as payment in full for the medical services and supplies provided to the CHAMPUS beneficiary, and has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing and deductible amounts paid by, or on behalf of, the beneficiary as full payment for the covered medical services or supplies. In addition, Participating Providers submit the appropriate claims forms to the appropriate CHAMPUS contractor on behalf of the beneficiary. There are several circumstances under which providers are Participating Providers.

b. Mandatory participation Medicare-participating hospitals are required by law to be Participating Providers on all inpatient claims under CHAMPUS. Hospitals that are not Medicare-participating providers but are subject to the CHAMPUS DRG-based payment system or the CHAMPUS mental health payment system (see Chapter 14.A.), must sign agreements to participate on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS.

c. Participating Provider Program.

(1) In general. An institutional provider not required to participate pursuant to paragraph A.8.b, of this chapter and any individual provider may become a Participating Provider by signing a Participating Provider agreement. In such an agreement, the provider agrees that all CHAMPUS claims filed during the time period covered by the agreement will be on a participating basis.

(2) Agreement required. Under the Participating Provider Program, the provider must sign an agreement or memorandum of understanding under which the provider agrees to become a Participating Provider. Such an agreement may be with the nearby military treatment facility, a CHAMPUS contractor, or other authorized official. Such an agreement may include other provisions pertaining to the Participating Provider Program. The Director, OCHAMPUS shall establish a standard model agreement and other procedures to promote uniformity in the administration of the Participating Provider Program.

(3) Relationship to other activities. Participating Provider agreements may include other provisions, such as provisions regarding discounts (see Chapter 14.1) or other provisions in connection with the delivery and financing of health care services, as authorized by this chapter or other DoD Directives or Instructions. Participating Provider agreement provisions may also be incorporated into other types of agreements, such as preferred provider arrangements where

such arrangements are established under CHAMPUS.

d. Claim-by-claim-participation. Institutional and individual providers that are not participating providers pursuant to paragraphs A.8.b., or c., of this chapter, may elect to participate on a claim-by-claim basis. They may do so by signing the appropriate space on the claims form and submitting it to the appropriate CHAMPUS contractor on behalf of the beneficiary.

9. Limitation to authorized institutional provider designation. Authorized institutional provider status granted to a specific institutional provider applicant does not extend to any institution-affiliated provider, as defined in Chapter 2 of this Regulation, of that specific applicant.

10. Authorized provider. A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized in this chapter to provide benefits under CHAMPUS. In addition, to be an authorized CHAMPUS provider, any hospital which is a CHAMPUS participating provider under Section A.7. of this chapter, shall be a participating provider for all care, services, or supplies furnished to an active duty member of the uniformed services for which the active duty member is entitled under title 10, United States Code, section 1074(c). As a participating provider for active duty members, the CHAMPUS authorized hospital shall provide such care, services, and supplies in accordance with the payment rules of Chapter 16. The failure of any CHAMPUS participating hospital to be a participating provider for any active duty member subjects the hospital to termination of the hospital's status as a CHAMPUS authorized provider for failure to meet the qualifications established by this chapter.

11. Submittal of claims by provider required.

a. General rule. Unless waived pursuant to paragraph A.11.b., of this chapter, every CHAMPUS-authorized institutional and individual provider is required to submit CHAMPUS claims to the appropriate CHAMPUS contractor on behalf of the beneficiary for all services and supplies. In addition, the provider may not impose any charge relating to completing and submitting the applicable claim form (or any other related information). (Although CHAMPUS encourages provider participation, this paragraph A.11., requires only the submission of claim forms by providers on behalf of beneficiaries; it does not require that providers accept assignment of beneficiaries' claims or become participating providers.)

b. Waiver of claims submission requirement. The requirement that providers submit claims on behalf of beneficiaries may be waived in circumstances set forth in this paragraph A.11.b. A decision by the Director, OCHAMPUS to waive or not to waive the requirement in any particular circumstance is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(1) General requirement for waiver. The requirement that providers submit claims on behalf of beneficiaries may be waived by the Director, OCHAMPUS when the Director determines that the waiver is necessary in order to ensure adequate access for CHAMPUS beneficiaries to health care services. However, the requirement may not be waived for Participating Providers (see paragraph A.8., of this chapter).

(2) Blanket waiver for provider outside the United States. The requirement

that providers submit claims is waived with respect to providers outside the United States (the United States includes Puerto Rico for this purpose).

(3) Blanket waiver in double coverage cases. The requirement that providers submit claims is waived in cases in which another insurance plan or program provides primary coverage for the services.

(4) Waivers for particular categories of care. The Director, OCHAMPUS may waive the requirement that providers submit claims if the Director determines that available evidence clearly shows that the requirement would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. The Director, OCHAMPUS may establish procedures for handling such petitions.

(5) Case-by-case waivers. On a case-by-case basis, the Director, OCHAMPUS may waive the provider's obligation to submit that claim if the Director determines that a waiver in that case is necessary in order to ensure adequate access for CHAMPUS beneficiaries to the health care services involved. Such case-by-case waivers may be requested by providers or beneficiaries pursuant to procedures established by the Director.

c. Remedies for noncompliance.

(1) In any case in which a provider fails to submit a claim, or charges an administrative fee for filing a claim (or any other related information), in violation of the requirements of this paragraph A.11., the amount that would otherwise be allowable for the claim shall be reduced by ten percent, unless the reduction is waived by the Director, OCHAMPUS based on special circumstances. The amount disallowed by such a reduction may not be billed to the patient (or the patient's sponsor or family).

(2) Repeated failures by a provider to comply with the requirements of this paragraph A.11., shall be considered abuse and/or fraud and grounds for exclusion or suspension of the provider under Chapter 9., of this regulation.

12. Balance billing limits.

a. In general. Individual providers who are not participation providers may not balance bill a beneficiary an amount which exceeds the applicable billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians.

b. Waiver. The balance billing limit may be waived by the Director, OCHAMPUS on a case-by-case basis if requested by a CHAMPUS beneficiary. A decision by the Director, OCHAMPUS to waive or not to waive the limit in any particular case is not subject to the appeal and hearing procedures in Chapter 10., of this regulation.

c. Compliance. Failure to comply with the balance billing limit shall be considered abuse and/or fraud and grounds for exclusion or suspension of the provider under Chapter 9., of this regulation.

B. INSTITUTIONAL PROVIDERS

1. General. Institutional providers are those providers who bill for services in the name of an organizational entity (such as hospital and skilled nursing facility), rather than in the name of a person. The term "institutional provider" does not include professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)), nor does it include other corporations that provide principally professional services. Institutional providers may provide medical services and supplies on either an inpatient or outpatient basis.

a. Preauthorization. Preauthorization may be required by the Director, OCHAMPUS for any health care service for which payment is sought under CHAMPUS. (See Chapters 4 and 15 for further information on preauthorization requirements.)

b. Billing practices.

(1) Each institutional billing, including those institutions subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, must be itemized fully and sufficiently descriptive for the CHAMPUS to make a determination of benefits.

(2) Institutional claims subject to the CHAMPUS DRG-based reimbursement method or a CHAMPUS-determined all-inclusive rate reimbursement method, may be submitted only after the beneficiary has been discharged or transferred from the institutional provider's facility or program.

(3) Institutional claims for Residential Treatment Centers and all other institutional providers, except those listed in subparagraph (2) above, should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days.

c. Medical records. Institutional providers must provide adequate contemporaneous clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and to identify the individual(s) who provided the care. The minimum requirements for medical record documentation are set forth by the following:

(1) The cognizant state licensing authority;

(2) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or other health care accreditation organizations as may be appropriate:

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(i) Professional staff. The center's professional staff is legally and professionally qualified for the performance of their professional responsibilities.

(j) Medical records. The center maintains full and complete written documentation of the services rendered to each woman admitted and each newborn delivered. A copy of the informed consent document required by subparagraph (c), above, which contains the original signature of the CHAMPUS beneficiary, signed and dated at the time of admission, must be maintained in the medical record of each CHAMPUS beneficiary admitted.

(k) Quality assurance. The center has an organized program for quality assurance which includes, but is not limited to, written procedures for regularly scheduled evaluation of each type of service provided, of each mother or newborn transferred to a hospital, and of each death within the facility.

(l) Governance and administration. The center has a governing body legally responsible for overall operation and maintenance of the center and a full-time employee who has authority and responsibility for the day-to-day operation of the center.

1. Psychiatric partial hospitalization programs. Psychiatric partial hospitalization programs must be either a distinct part of an otherwise authorized institutional provider or a freestanding program. The treatment program must be under the general direction of a psychiatrist employed by the partial hospitalization program to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be a CHAMPUS authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, certified psychiatric nurse specialists, clinical social workers, marriage and family counselors, pastoral counselors and mental health counselors. CHAMPUS reimbursement is limited to programs complying with all requirements of Chapter 4, paragraph B.10. In addition, in order for a partial hospitalization program (PHP) to be authorized, the PHP shall comply with the following requirements:

(1) The PHP shall comply with the CHAMPUS Standards for Partial Hospitalization Programs and Facilities, as promulgated by the Director, OCHAMPUS.

(2) The PHP shall be specifically accredited by and remain in substantial compliance with standards issued by the Joint Commission on Accreditation of Healthcare Organizations under the Mental Health Manual (formerly the Consolidated Standards). NOTE: A one-time grace period is being allowed not to exceed October 1, 1994 for this provision only if the provider is already accredited under the JCAHO hospital standards. The provider must agree not to accept any new admissions for CHAMPUS patients for care beyond October 1, 1994, if accreditation and substantial compliance with the Mental Health Manual standards have not been obtained by that date.

(3) The PHP shall be licensed as a partial hospitalization program to provide PHP services within the applicable jurisdiction in which it operates.

(4) The PHP shall accept the CHAMPUS-allowable partial hospitalization program rate, as provided in Chapter 14, paragraph A.2.i., as payment in full for services provided.

(5) The PHP shall comply with all requirements of this section applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review and other matters.

(6) The PHP must be fully operational and treating patients for a period of at least six months (with at least 30 percent minimum patient census) before an application for approval may be submitted. The PHP shall not be considered a CHAMPUS-authorized provider nor may any CHAMPUS benefits be paid to the facility for any services provided prior to the date the facility is approved by the Director, OCHAMPUS, or designee.

(7) All mental health services must be provided by a CHAMPUS-authorized mental health provider. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.] All other program services shall be provided by trained, licensed staff.

(8) The PHP shall ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by a CHAMPUS authorized mental health provider.

(9) The PHP must have a written agreement with at least one backup CHAMPUS-authorized hospital which specifies that the hospital will accept any and all CHAMPUS beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

(10) The PHP shall enter into a participation agreement with the Director, OCHAMPUS, which shall include but which shall not be limited to the following provisions:

(a) The PHP agrees not to bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization or concurrent care review.

(b) The PHP agrees not to bill the beneficiary for services excluded on the basis of Chapter 4, paragraphs G.1. (not medically necessary), G.3. (inappropriate level of care) or G.7. (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question had been determined noncovered by CHAMPUS. (A general statement signed at admission as to financial liability does not fulfill this requirement.)

C. INDIVIDUAL PROFESSIONAL PROVIDERS OF CARE

1. General. Individual professional providers of care are those providers who bill for their services on a fee-for-service basis and are not employed or

under a contract which provides for payment to the individual professional provider by an institutional provider. This category also includes those individuals who have formed professional corporations or associations qualifying as a domestic corporation under section 301.7701-5 of the Internal Revenue Service Regulations (reference (cc)). Such individual professional providers must be licensed or certified by the local licensing or certifying agency for the jurisdiction in which the care is provided; or in the absence of state licensure/certification, be a member of or demonstrate eligibility for full clinical membership in, the appropriate national or professional certifying association that sets standards for the profession of which the provider is a member. Services provided must be in accordance with good medical practice and prevailing standards of quality of care and within recogn'zed utilization norms.

a. Licensing/Certification required, scope of license. Otherwise covered services shall be cost-shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered. Licensure/certification must be at the full clinical practice level. The services provided must be within the scope of the license, certification or other legal authorization. Licensure or certification is required to be a CHAMPUS authorized provider if offered in the jurisdiction where the service is rendered, whether such licensure or certification is required by law or provided on a voluntary basis. The requirement also applies for those categories of providers that would otherwise be exempt by the state because the provider is working in a non-profit, state-owned or church setting. Licensure/certification is mandatory for a provider to become a CHAMPUS-authorized provider.

b. Monitoring required. The Director, OCHAMPUS, or a designee, shall develop appropriate monitoring programs and issue guidelines, criteria, or norms necessary to ensure that CHAMPUS expenditures are limited to necessary medical supplies and services at the most reasonable cost to the government and beneficiary. The Director, OCHAMPUS, or a designee, also will take such steps as necessary to deter overutilization of services.

c. Christian Science. Christian Science practitioners and Christian Science nurses are authorized to provide services under CHAMPUS. Inasmuch as they provide services of an extramedical nature, the general criteria outlined above do not apply to Christian Science services (refer to subparagraph C.3.d.(2), below, regarding services of Christian Science practitioners and nurses).

d. Physician referral and supervision. Physician referral and supervision is required for the services of paramedical providers as listed in subparagraph C.3.c.8. and for pastoral counselors, and mental health counselors. Physician referral means that the physician must actually see the patient, perform an evaluation, and arrive at an initial diagnostic impression prior to referring the patient. Documentation is required of the physician's examination, diagnostic impression, and referral. Physician supervision means that the physician provides overall medical management of the case. The physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

e. Medical records: Individual professional providers must maintain adequate clinical records to substantiate that specific care was actually furnished, was medically necessary, and appropriate, and identify(ies) the individual(s) who provided the care. This applies whether the care is inpatient or outpatient. The minimum requirements for medical record documentation are set forth by the following:

(1) The cognizant state licensing authority;

(2) The Joint Commission on Accreditation of Healthcare Organizations, or other health care accreditation organizations as may be appropriate;

(3) Standards of practice established by national medical organizations; and

(4) This Regulation.

2. Interns and residents. Interns and residents may not be paid directly by CHAMPUS for services rendered to a beneficiary when their services are provided as part of their employment (either salaried or contractual) by a hospital or other institutional provider.

(c) Has had a minimum of 2 years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the Director, OCHAMPUS, or a designee.

NOTE: Patients' organic medical problems must receive appropriate concurrent management by a physician.

(7) Certified psychiatric nurse specialist. A certified psychiatric nurse specialist may provide covered care independent of physician referral and supervision. For purposes of CHAMPUS, a certified psychiatric nurse specialist is an individual who:

(a) Is a licensed, registered nurse; and

(b) Has at least a master's degree in nursing from a regionally accredited institution with a specialization in psychiatric and mental health nursing; and

(c) Has had at least 2 years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of 8 hours of direct patient contact per week; or

(d) Is listed in a CHAMPUS-recognized, professionally sanctioned listing of clinical specialists in psychiatric and mental health nursing.

(8) Certified physician assistant. A physician assistant may provide care under general supervision of a physician (see Chapter 14 G.1.c. for limitations on reimbursement). For purposes of CHAMPUS, a physician assistant must meet the applicable state requirements governing the qualifications of physician assistants and at least one of the following conditions:

(a) Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians, or

(b) Has satisfactorily completed a program for preparing physician assistants that:

1 Was at least 1 academic year in length;

2 Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

3 Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

(c) Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of subparagraph (1)(b) of this paragraph and had been assisting primary care physicians for a minimum of 12 months during the 18-month period immediately preceding January 1, 1987.

(9) Other individual paramedical providers. The services of the following individual professional providers of care to be considered for benefits on a fee-for-service basis may be provided only if the beneficiary is referred by a physician for the treatment of a medically-diagnosed condition and a physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by these individual paramedical providers.

(a) Licensed registered nurses.

(b) Licensed practical or vocational nurses.

(c) Licensed registered physical therapists.

(d) Audiologists.

(e) Speech therapists (speech pathologists).

d. Extramedical individual providers. Extramedical individual providers are those who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field. The services of extramedical individual professionals are coverable following the CHAMPUS determined allowable charge methodology provided such services are otherwise authorized in this or other chapters of the regulation.

(1) Certified marriage and family therapists. For the purposes of CHAMPUS, a certified marriage and family therapist is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following [illegible]ience:

1 Either 200 [illegible] of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice as a marriage and family therapist by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) Agrees that a patients' organic medical problems must receive appropriate concurrent management by a physician.

(e) Agrees to accept the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, and hold CHAMPUS beneficiaries harmless for noncovered care (i.e., may not bill a beneficiary for noncovered care, and may not balance bill a beneficiary for amounts above the allowable charge). The certified marriage and family therapist must enter into a participation agreement with the Office of CHAMPUS within which the certified marriage and family therapist agrees to all provisions specified above.

(f) As of the effective date of termination, the certified marriage and family therapist, will no longer be recognized as an authorized provider under CHAMPUS. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized CHAMPUS extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

(2) Pastoral counselors. For the purposes of CHAMPUS a pastoral counselor is an individual who meets the following requirements:

(a) Recognized graduate professional education with the minimum of an earned master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline; and

(b) The following experience:

1 Either 200 hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a 2- to 3-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and

2 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases; or

3 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a 2- to 3-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than 1 nor more than 2 years; and

4 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases; and

(c) Is licensed or certified to practice by the jurisdiction where practicing (see C.3.d.(4) of this part for more specific information regarding licensure); and

(d) The services of a pastoral counselor meeting the above requirements are coverable following the CHAMPUS determined allowable charge methodology, under the following specified conditions:

1 The CHAMPUS beneficiary must be referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The pastoral counselor must certify on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(e) Because of the similarity of the requirements for licensure, certification, experience and education a pastoral counselor may elect to be authorized under CHAMPUS as a certified marriage and family therapist, and as such, be subject to all previously defined criteria for the certified marriage and family therapist category, to include acceptance of the CHAMPUS determined allowable charge as payment in full, except for applicable deductibles and cost-shares, (i.e., balance billing of a beneficiary above the allowable charge is prohibited; may not bill beneficiary for noncovered care). The pastoral counselor must also agree to enter into the same participation agreement as a certified marriage and family therapist with the Office of CHAMPUS within which the pastoral counselor agrees to all provisions, including licensure, national association membership and conditions upon termination, outlined above for certified marriage and family therapists.

NOTE: No dual status will be recognized by the Office of CHAMPUS. Pastoral counselors must elect to become one of the categories of extramedical CHAMPUS providers specified above. Once authorized as either a pastoral counselor,

or a certified marriage and family therapist, claims review and reimbursement will be in accordance with the criteria established for the elected provider category.

(3) Mental Health Counselor. For the purposes of CHAMPUS, a mental health counselor is an individual who meets the following requirements:

(a) Minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and

(b) Two years of post-master's experience which includes 3000 hours of clinical work and 100 hours of face-to-face supervision; and

(c) Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing (see C.3.d.(4) of this part for more specfic information); and

(d) May only be reimbursed when:

1 The CHAMPUS beneficiary is referred for therapy by a physician; and

2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

3 The mental health counselor certifies on each claim for reimbursement that a written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician (refer to Chapter 7).

(4) The following additional information applies to each of the above categories of extramedical individual providers:

(a) These providers must also be licensed or certified to practice as a certified marriage and family therapist, pastoral counselor or mental health counselor by the jurisdiction where practicing. In jurisdictions that do not provide for licensure or certification, the provider must be certified by or eligible for full clinical membership in the appropriate national professional association that sets standards for the specific profession.

(b) Grace period for therapists or counselors in states where licensure/certification is optional. CHAMPUS is providing a grace period for those therapists or counselors who did not obtain optional licensure/certification in their jurisdiction, not realizing it was a CHAMPUS requirement for authorization. The exemption by state law for pastoral counselors may have misled this group into thinking licensure was not required. The same situation may have occurred with the other therapist or counselor categories. This grace period pertains only to the licensure/certification requirement, applies only to therapists or counselors who

are already approved as of October 29, 1990, and only in those areas where the licensure/certification is optional. Any therapist or counselor who is not licensed/certified in the state in which he/she is practicing by August 1, 1991, will be terminated under the provisions of Section 199.9 of this part. This grace period does not change any of the other existing requirements which remain in effect. During this grace period, membership or proof of eligibility for full clinical membership in a recognized professional association is required for those therapists or counselors who are not licensed or certified by the state. The following organizations are recognized for therapists or counselors at the level indicated: full clinical member of the American Association of Marriage and Family Therapy; membership at the fellow or diplomate level of the American Association of Pastoral Counselors; and membership in the National Academy of Certified Clinical Mental Health Counselors. Acceptable proof of eligibility for membership is a letter from the appropriate certifying organization. This opportunity for delayed certification/licensure is limited to the counselor or therapist category only as the language in all of the other provider categories has been consistent and unmodified from the time each of the other provider categories were added. The grace period does not apply in those states where licensure is mandatory.

(5) Christian Science practitioners and Christian Science nurses. CHAMPUS cost shares the services of Christian Science practitioners and nurses. In order to bill as such, practitioners or nurses must be listed or be eligible for listing in the Christian Science Journal at the time the service is provided.

D. OTHER PROVIDERS

Certain medical supplies and services of an ancillary or supplemental nature are coverable by CHAMPUS, subject to certain controls. This category of provider includes the following:

1. Independent laboratory. Laboratory services of independent laboratories may be cost-shared if the laboratory is approved for participation under Medicare and certified by the Medicare Bureau, Health Care Financing Administration.

2. Suppliers of portable x-ray services. Such suppliers must meet the conditions of coverage of the Medicare program, set forth in the Medicare regulations (reference (h)), or the Medicaid program in that state in which the covered service is provided.

3. Pharmacies. Pharmacies must meet the applicable requirements of state law in the state in which the pharmacy is located.

4. Ambulance companies. Such companies must meet the requirements of state and local laws in the jurisdiction in which the ambulance firm is licensed.

5. Medical equipment firms, medical supply firms. As determined by the Director, OCHAMPUS, or a designee.

6. Mammography Suppliers. Mammography services may be cost-shared only if the supplier is certified by Medicare for participation as a mammography supplier, or is certified by the American College of Radiology as having met its mammography supplier standards.

E. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

F. EXCLUSION

Regardless of any provision in this chapter, a provider who is suspended, excluded, or terminated under Chapter 9 of this Regulation is specifically excluded as an authorized CHAMPUS provider.

CHAPTER 7

CLAIMS SUBMISSION, REVIEW, AND PAYMENT

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b. Physician or other authorized individual professional provider. A physician or other authorized individual professional provider is liable for any signature submitted on his or her behalf. Further, a facsimile signature is not acceptable unless such facsimile signature is on file with, and has been authorized specifically by, the CHAMPUS fiscal intermediary serving the state where the physician or other authorized individual professional provider practices.

c. Hospital or other authorized institutional provider. The provider signature on a claim form for institutional services must be that of an authorized representative of the hospital or other authorized institutional provider, whose signature is on file with and approved by the appropriate CHAMPUS fiscal intermediary.

D. Claims filing deadline. For all services provided on or after January 1, 1993, to be considered for benefits, all claims submitted for benefits must, except as provided in paragraph D.2., of this Chapter, be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided. Unless the requirement is waived, failure to file a claim within this deadline waives all rights to benefits for such services or supplies.

1. Claims returned for additional information. When a claim is submitted initially within the claim filing time limit, but is returned in whole or in part for additional information to be considered for benefits, the returned claim, along with the requested information must be resubmitted and received by the appropriate CHAMPUS contractor no later than the later of: (1) one year after the services are provided; or (2) 90 days from the date the claim was returned to the provider or beneficiary.

2. Exception to claims filing deadline. The Director, OCHAMPUS, or a designee, may grant exceptions to the claims filing deadline requirements.

a. Types of exception

(1) Retroactive eligibility. Retroactive CHAMPUS eligibility determinations.

(2) Administrative error. Administrative error (that is, misrepresentation, mistake, or other accountable action) of an officer or employee of OCHAMPUS (including OCHAMPUSEUR) or a CHAMPUS fiscal intermediary, performing functions under CHAMPUS and acting within the scope of that official's authority.

(3) Mental incompetency. Mental incompetency of the beneficiary or guardian or sponsor, in the case of a minor child (which includes inability to communicate, even if it is the result of a physical disability).

(4) Provider billings. Direct billings by participating providers.

(5) Delays by other health insurance. When not attributable to the beneficiary, delays in adjudication by other health insurance companies when double coverage coordination is required before the CHAMPUS benefit determination.

b. Request for exception to claims filing deadline. Beneficiaries who wish to request an exception to the claims filing deadline may submit such a request to the CHAMPUS fiscal intermediary having jurisdiction over the location in which the service was rendered, or as otherwise designated by the Director, OCHAMPUS.

(1) Such requests for an exception must include a complete explanation of the circumstances of the late filing, together with all available documentation supporting the request, and the specific claim denied for late filing.

(2) Each request for an exception to the claims filing deadline is reviewed individually and considered on its own merits.

E. Other waiver authority. The Director, OCHAMPUS may waive the claims filing deadline in other circumstances in which the Director determines that the waiver is necessary in order to ensure adequate access for CHAMPUS beneficiaries to health care services.

1. Continuing care. Except for claims subject to the CHAMPUS DRG-based payment system, whenever medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary or sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, OCHAMPUS, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing basis are outpatient physical therapy, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS DRG-based payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

2. Inpatient mental health services. Under most circumstances, the 60-day inpatient mental health limit applies to the first 60 days of care paid in a calendar year. The patient will be notified when the first 30 days of inpatient mental health benefits have been paid. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not yet billed during the same calendar year by a different provider.

3. Claims involving the services of marriage and family counselors, pastoral counselors, and mental health counselors. CHAMPUS requires that certified marriage and family therapists, pastoral counselors, and mental health counselors make a written report to the referring physician concerning the CHAMPUS beneficiary's progress. Therefore, each claim for reimbursement for services of marriage and family counselors, pastoral counselors, and mental health counselors must include certification to the effect that a written communication has been made or will be made to the referring physician at the end of treatment, or more frequently, as required by the referring physician.

F. PREAUTHORIZATION

When specifically required in other chapters of this Regulation, preauthorization requires the following:

1. Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such preauthorization shall be submitted and approved before benefits may be extended, except as provided in Chapter 4, subsection A.11. If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, OCHAMPUS, or a designee, has granted an exception to the requirement for preauthorization.

a. Specifically preauthorized services. An approved preauthorization specifies the exact services or supplies for which authorization is being given. In a preauthorization situation, benefits cannot be extended for services or supplies provided beyond the specific authorization.

b. Time limit on preauthorization. Approved preauthorizations are valid for specific periods of time, appropriate for the circumstances presented and specified at the time the preauthorization is approved. In general, preauthorizations are valid for 30 days. If the preauthorized service or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended.

2. Treatment plan, management plan. Each preauthorization request shall be accompanied by a proposed medical treatment plan (for inpatient stays under the Basic Program) or management plan (for services under the PFTH) which shall include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed type and extent of treatment or therapy; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

3. Durable equipment. Requests for preauthorization to purchase durable equipment under the PFTH must list all items of durable equipment previously authorized under the PFTH and state whether the current item of equipment is the initial purchase or a replacement. If it is a replacement item, the date the initial item was purchased also shall be provided.

4. Claims for services and supplies that have been preauthorized. Whenever a claim is submitted for benefits under CHAMPUS involving preauthorized services and supplies, the date of the approved preauthorization must be indicated on the claim form and a copy of the written preauthorization must be attached to the appropriate CHAMPUS claim.

G. CLAIMS REVIEW

It is the responsibility of the CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR) to review each CHAMPUS claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this Regulation. It is also required that before any CHAMPUS benefits may be extended, claims for medical services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, OCHAMPUS, or a designee (see paragraph A.1.e. of Chapter 14 for review standards for claims subject to the CHAMPUS DRG-based payment system).

H. BENEFIT PAYMENTS

CHAMPUS benefit payments are made either directly to the beneficiary or sponsor or to the provider, depending on the manner in which the CHAMPUS claim is submitted.

1. Benefit payments made to beneficiary or sponsor. When the CHAMPUS beneficiary or sponsor signs and submits a specific claim form directly to the appropriate CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR), any CHAMPUS benefit payments due as a result of that specific claim submission will be made in the name of, and mailed to, the beneficiary or sponsor. In such circumstances, the beneficiary or sponsor is responsible to the provider for any amounts billed.

2. Benefit payments made to participating provider. When the authorized provider elects to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in Chapters 4 and 5 of this Regulation.

3. CEOB. When a CHAMPUS claim is adjudicated, a CEOB is sent to the beneficiary or sponsor. A copy of the CEOB also is sent to the provider if the claim was submitted on a participating basis. The CEOB form provides, at a minimum, the following information:

CHAPTER 14

PROVIDER REIMBURSEMENT METHODS

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CHAPTER 14
PROVIDER REIMBURSEMENT METHODS

A. HOSPITALS

The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

1. CHAMPUS Diagnosis Related Group(DRG)-based payment system. Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished by hospitals subject to the system is made on the basis of prospectively-determined rates and applied on a per discharge basis using DRGs. Payments under this system will include a differentiation for urban (using large urban and other urban areas) and rural hospitals and an adjustment for area wage differences and indirect medical education costs. Additional payments will be made for capital costs, direct medical education costs, and outlier cases.

a. General.

(1) DRGs used. The CHAMPUS DRG-based payment system will use the same DRGs used in the most recently available grouper for the Medicare Prospective Payment System, except as necessary to recognize distinct characteristics of CHAMPUS beneficiaries and as described in instructions issued by the Director, OCHAMPUS.

(2) Assignment of discharges to DRGs.

(a) The classification of a particular discharge shall be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed and discharge status. In addition, for neonatal cases (other than normal newborns) the classification shall also account for birthweight, surgery and the presence of multiple, major and other neonatal problems, and shall incorporate annual updates to these classification features.

(b) Each discharge shall be assigned to only one DRG regardless of the number of conditions treated or services furnished during the patient's stay.

(3) Basis of payment.

(a) Hospital billing. Under the CHAMPUS DRG-based payment system, hospitals are required to submit claims (including itemized charges) in accordance with Chapter 7, paragraph B. The CHAMPUS fiscal intermediary will assign the appropriate DRG to the claim based on the information contained on the claim. Any request from a hospital for reclassification of a claim to a higher weighted DRG must be submitted, within 60 days from the date of the initial payment, in a manner prescribed by the Director, OCHAMPUS.

(b) Payment on a per discharge basis. Under the CHAMPUS DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to CHAMPUS beneficiaries.

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(c) Claims priced as of date of admission. Except for interim claims submitted for qualifying outlier cases, all claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of admission, regardless of when the claim is submitted.

(d) Payment in full. The DRG-based amount paid for inpatient hospital services is the total CHAMPUS payment for the inpatient operating costs (as described in subparagraph A.1.a.(3)(e)) incurred in furnishing services covered by the CHAMPUS. The full prospective payment amount is payable for each stay during which there is at least one covered day of care, except as provided in subparagraph A.1.c.(5)(a)1a.

(e) Inpatient operating costs. The CHAMPUS DRG-based payment system provides a payment amount for inpatient operating costs, including:

1 Operating costs for routine services; such as the costs of room, board, and routine nursing services;

2 Operating costs for ancillary services, such as hospital radiology and laboratory services (other than physicians' services) furnished to hospital inpatients;

3 Special care unit operating costs; and

4 Malpractice insurance costs related to services furnished to inpatients.

(f) Discharges and transfers.

1 Discharges. A hospital inpatient is discharged when:

a The patient is formally released from the hospital (release of the patient to another hospital as described in subparagraph 2 of this subparagraph, or a leave of absence from the hospital, will not be recognized as a discharge for the purpose of determining payment under the CHAMPUS DRG-based payment system);

b The patient dies in the hospital; or

c The patient is transferred from the care of a hospital included under the CHAMPUS DRG-based payment system to a hospital or unit that is excluded from the prospective payment system.

2 Transfers. Except as provided under subparagraph A.1.a.(3)(f)1, a discharge of a hospital inpatient is not counted for purposes of the CHAMPUS DRG-based payment system when the patient is transferred:

a From one inpatient area or unit of the hospital to another area or unit of the same hospital;

or state as established by local or state regulatory authority, excluding title XIX of the Social Security Act or other welfare program, when extended to CHAMPUS beneficiaries by consent or agreement.

4. CHAMPUS discount rates. The CHAMPUS-determined allowable cost for authorized care in any hospital may be based on discount rates established under section I. of this chapter.

B. SKILLED NURSING FACILITIES (SNFs)

The CHAMPUS-determined allowable cost for reimbursement of a SNF shall be determined on the same basis as for hospitals which are not subject to the CHAMPUS DRG-based payment system.

C. REIMBURSEMENT FOR OTHER THAN HOSPITALS AND SNFs

The Director, OCHAMPUS, or a designee, shall establish such other methods of determining allowable cost or charge reimbursement for those institutions, other than hospitals and SNFs, as may be required.

D. Payment of Institutional facility costs for ambulatory surgery.

1. In general. CHAMPUS pays institutional facility costs for ambulatory surgery on the basis of prospectively determined amounts, as provided in this paragraph. This payment method is similar to that used by the Medicare program for ambulatory surgery. This paragraph applies to payment for institutional charges for ambulatory surgery provided in hospitals and freestanding ambulatory surgical centers. It does not apply to professional services. A list of ambulatory surgery procedures subject to the payment method set forth in this paragraph shall be published periodically by the Director OCHAMPUS. Payment to freestanding ambulatory surgery centers is limited to these procedures.

2. Payment in full. The payment provided for under this paragraph is the payment in full for services covered by this paragraph. Facilities may not charge beneficiaries for amounts, if any, in excess of the payment amounts determined pursuant to this paragraph.

3. Calculation of standard payment rates. Standard payment rates are calculated for groups of procedures under the following steps:

a. Step 1: calculate a median standardized cost for each procedure. For each ambulatory surgery procedure, a median standardized cost will be calculated on the basis of all ambulatory surgery charges nationally under CHAMPUS during a recent one-year base period. The steps in this calculation include standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare, applying a cost-to-charge ratio, calculating a median cost for each procedure, and updating to the year for which the payment rates will be in effect by the Consumer Price Index-Urban. In applying a cost-to-charge ratio, the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers (FASCs) will be used for all charges from FASCs, and the Medicare cost-to-charge ratio for hospital outpatient settings will be used for all charges from hospitals.

b. Step 2: grouping procedures. Procedures will then be placed into one of ten groups by their median per procedure cost, starting with $0 to $299 for group 1 and ending with $1000 to $1299 for group 9 and $1300 and above for group 10, with groups 2 through 8 set on the basis of $100 fixed intervals.

c. Step 3: adjustments to groups. The Director, OCHAMPUS may make adjustments to the groupings resulting from step 2 to account for any ambulatory surgery procedures for which there were insufficient data to allow a grouping or to correct for any anomalies resulting from data or statistical factors or other special factors that fairness requires be specially recognized. In making any such adjustments, the Director may take into consideration the placing of particular procedures in the ambulatory surgery groups under Medicare.

d. Step 4: standard payment amount per group. The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

e. Step 5: actual payments. Actual payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare.

4. Multiple procedures. In cases in which authorized multiple procedures are performed during the same operative session, payment shall be based on 100 percent of the payment amount for the procedure with the highest ambulatory surgery payment amount, plus, for each other procedure performed during the session, 50 percent of its payment amount.

5. Annual updates. The standard payment amounts will be updated annually by the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments.

6. Recalculation of rates. The Director, OCHAMPUS, may periodically recalculate standard payment rates for ambulatory surgery using the steps set forth in paragraph D.3., of this Chapter.

E. REIMBURSEMENT OF BIRTHING CENTERS

1. Reimbursement for maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the CHAMPUS established all-inclusive rate or the center's most-favored all-inclusive rate.

2. The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, post-partum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility.

3. The CHAMPUS established all-inclusive rate is equal to the sum of the CHAMPUS area prevailing professional charge for total obstetrical care for a normal pregnancy and delivery and the sum of the average CHAMPUS allowable institutional charges for supplies, laboratory, and delivery room for a hospital inpatient normal

delivery. The CHAMPUS established all-inclusive rate areas will coincide with those established for prevailing professional charges and will be updated concurrently with the CHAMPUS area prevailing professional charge database.

4. Extraordinary maternity care services, when otherwise authorized, may be reimbursed at the lesser of the billed charge or the CHAMPUS allowable charge.

RESERVED

G. REIMBURSEMENT OF INDIVIDUAL HEALTH-CARE PROFESSIONALS AND OTHER NON-INSTITUTIONAL HEALTH-CARE PROVIDERS

The CHAMPUS-determined reasonable charge (the amount allowed by CHAMPUS) for the service of an individual health-care professional or other non-institutional health-care provider (even if employed by or under contract to an institutional provider) shall be determined by one of the following methodologies, that is, whichever is in effect in the specific geographic location at the time covered services and supplies are provided to a CHAMPUS beneficiary.

1. Allowable charge method.

a. Introduction

(1) In general. The allowable charge method is the preferred and primary method for reimbursement of individual health care professionals and other non-institutional health care providers (covered by 10 U.S.C. 1079(h)(1)). The allowable charge for authorized care shall be the lower of the billed charge or the local CHAMPUS Maximum Allowable Charge (CMAC) level.

(2) CHAMPUS Maximum Allowable Charge. Beginning in calendar year 1992, prevailing charge levels and appropriate charge levels will be calculated on a national level. There will then be calculated a national CHAMPUS Maximum Allowable Charge (CMAC) level for each procedure, which shall be the lesser of the national prevailing charge level or the national appropriate charge level. The national CMAC will then be adjusted for localities in accordance with paragraph G.1.d., of this Chapter.

(3) Differential for Participating Providers. Beginning in calendar year 1994, there shall be a differential in national and local CMACs based on whether the provider is a participating provider or a nonparticipating provider. The differential shall be calculated so that the CMAC for the nonparticipating providers is 95 percent of the CMAC for the participating providers. To assure the effectiveness of the several phase-in and waiver provisions set forth in paragraphs G.1.c., and G.1.d., of this Chapter, beginning in calendar year 1994, there will first be calculated the national and local CMACs for nonparticipating providers. For purposes of this calculation, the identification of overpriced procedures called for in pargagraph G.1.C.a., of this chapter and the calculation of appropriate charge levels for such overpriced procedures called for in paragraph G.1.D.(2), of this Chapter shall use as the Medicare fee component of the comparisons and calculations the fee level applicable to Medicare nonparticipating providers, which is 95 percent of the basic fee level. After nonparticipating provider local CMACs are calculated (including consideration of special phase-in rules and waiver rules in paragraph G.1.d., of this Chapter) participating provider local CMACs will be calculated so that nonparticipating provider local CMACs ar 05 percent of participating provider local CMACs. (For more information on the Participating Provider Program, see Chapter 6.A.8).

(4) Limits on balance billing by nonparticipating providers. Nonparticipating providers may not balance bill a beneficiary an amount which exceeds the applicable balance billing limit. The balance billing limit shall be the same percentage as the Medicare limiting charge percentage for nonparticipating physicians. The balance billing limit may be waived by the Director, OCHAMPUS

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on a case-by-case basis if requested by the CHAMPUS beneficiary (or sponsor) involved. A decision by the Director to waive or not waive the limit in any particular case is not subject to the appeal and hearing procedures of Chapter 10., of this regulation.

b. Prevailing charge level.

(1) Beginning in calendar year 1992, the prevailing charge level shall be calculated on a national basis.

(2) The national prevailing charge level referred to in paragraph G.1.b.(1) of this section is the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period. The 80th percentile of charges shall be determined on the basis of statistical data and methodology acceptable to the Director, OCHAMPUS (or a designee).

(3) For purposes of paragraph G.1.b.(2) of this section, the base period shall be a period of 12 calendar months and shall be adjusted once a year, unless the Director, OCHAMPUS determines that a different period for adjustment is appropriate and publishes a notice to that effect in the Federal Register.

c. Appropriate charge level. Beginning in calendar year 1992, the appropriate charge level for each procedure is the product of the two-step process set forth in paragraphs G.1.(c)(1) and (2) of this Chapter. This process involves comparing the prior year's CMAC with the fully phased in Medicare fee. For years after the Medicare fee has been fully phased in, the comparison shall be to the current Medicare fee. For any particular procedure for which comparable Medicare fee and CHAMPUS data are unavailable, but for which alternative data are available that the Director, OCHAMPUS (or designee) determines provide a reasonable approximation of relative value or price, the comparison may be based on such alternative data.

(1) Step 1: procedures classified. All procedures are classified into one of three categories, as follows:

(a) Overpriced procedures. These are the procedures for which the prior year's national CMAC exceeds the Medicare fee.

(b) Other procedures. These are procedures subject to the allowable charge method that are not included in either the overpriced procedures group or the underpriced procedures group.

(c) Underpriced procedures. These are the procedures for which the prior year's national CMAC is less than the Medicare fee.

(2) Step 2: calculating appropriate charge levels. For each year, appropriate charge levels will be calculated by adjusting the prior year's CMAC as follows:

(a) For overpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, reduced by the lesser of: the percentage by which it exceeds the Medicare fee or fifteen percent.

(b) For other procedures, the appropriate charge level for each procedure shall be the same as the prior year's CMAC.

(c) For underpriced procedures, the appropriate charge level for each procedure shall be the prior year's CMAC, increased by the lesser of: the percentage by which it is exceeded by the Medicare fee or the Medicare Economic Index.

c. Special rule for cases in which the CHAMPUS appropriate charge was prematurely reduced. In any case in which a recalculation of the Medicare fee results in a Medicare rate higher than the CHAMPUS appropriate charge for a procedure that had been considered an overpriced procedure, the reduction in the CHAMPUS appropriate charge shall be restored up to the level of the recalculated Medicare rate.

d. Calculating CHAMPUS Maximum Allowable Charge levels for localities.

(1) In general. The national CHAMPUS Maximum Allowable Charge level for each procedure will be adjusted for localities using the same (or similar) geographical areas and the same geographic adjustment factors as are used for determining allowable charges under Medicare.

(2) Special locality-based phase-in provision.

(a) In general. Beginning with the recalculation of CMACs for calendar year 1993, the CMAC in a locality will not be less than 72.25 percent of the maximum charge level in effect for that locality on December 31, 1991. For recalculations of CMACs for calendar years after 1993, the CMAC in a locality will not be less than 85 percent of the CMAC in effect for that locality at the end of the prior calendar year.

(b) Exception. The special locality-based phase-in provision established by Section G.1.d.(2)(a) of this Chapter shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services.

(3) Special locality-based waivers of reductions to assure adequate access to care. Beginning with the recalculation of CMACs for calendar year 1993, in the case of any procedure classified as an overpriced procedure pursuant to section G.1.c.(1)(a) of this Chapter, a reduction in the CMAC in a locality below the level in effect at the end of the previous calendar year that would otherwise occur pursuant to sections G.1.c., and G.1.d., of this Chapter may be waived pursuant to this section G.1.c.(3).

(a) Waiver based on balance billing rates. Except as provided in section G.1.d.(3)(b) of this Chapter such a reduction will be waived if there has been excessive balance billing in the locality for the procedure

involved. For this purpose, the extent of balance billing will be determined based on a review of all services under the procedure code involved in the prior year (or most recent period for which data are available). If the number of services for which balance billing was not required was less than 60 percent of all services provided, the Director will determine that there was an excessive balance billing with respect to that procedure in that locality and will waive the reduction in the CMAC that would otherwise occur. A decision by the Director to waive or not to waive the reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

(b) Exception. As an exception to section G.1.d.(3)(a) of this Chapter, the waiver required by that section shall not be applicable in the case of any procedure code for which there were not CHAMPUS claims in the locality accounting for at least 50 services. A waiver may, however, be granted in such cases pursuant to section G.1.d.(3)(c) of this Chapter.

(c) Waiver based on other evidence that adequate access to care would be impaired. The Director, OCHAMPUS may waive a reduction that would otherwise occur (or restore a reduction that was already taken) if the Director determines that available evidence shows that the reduction would impair adequate access. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the area, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access would be impaired. The Director, OCHAMPUS will consider and respond to all such petitions. Petitions may be filed at any time. Any petition received by the date which is 120 days prior to the implementation of a recalculation of CMACs will be assured of consideration prior that implementation. The Director, OCHAMPUS may establish procedures for handling petitions. A decision by the Director to waive or not to waive a reduction is not subject to the appeal and hearing procedures of Chapter 10 of this regulation.

e. Special rules for 1991.

(1) Prevailing charge levels for care provided on or after January 1, 1991, and before the 1992 prevailing charge levels take effect shall be the same as those in effect on December 31, 1990, except that prevailing charge levels for care provided on or after October 7, 1991 shall be those established pursuant to this paragraph G.1.e. of this section.

(2) Appropriate charge levels will be established for each locality for which a prevailing charge level was in effect immediately prior to October 7, 1991. For each procedure, the appropriate charge level shall be the prevailing charge level in effect immediately prior to October 7, 1991, adjusted as provided in G.1.e.(2)(a) through (c) of this section.

(a) For each overpriced procedure, the level shall be reduced by fifteen percent. For this purpose, overpriced procedures are the procedures determined by the Physician Payment Review Commission to be overvalued pursuant to the process established under the Medicare program, other procedures

considered overvalued in the Medicare program (for which Congress directed reductions in Medicare allowable levels for 1991), radiology procedures and pathology procedures.

(b) For each other procedure, the level shall remain unchanged. For this purpose, other procedures are procedures which are not overpriced procedures or primary care procedures.

(c) For each primary care procedure, the level shall be adjusted by the MEI, as the MEI is applied to Medicare prevailing charge levels. For this purpose, primary care procedures include maternity care and delivery services and well baby care services.

f. Special transition rule for 1992.

(1) For purposes of calculating the national appropriate charge levels for 1992, the prior year's appropriate charge level for each service will be considered to be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the base period of July 1, 1986 to June 30, 1987 (determined as under paragraph G.1.b.(2) of this section), adjusted to calendar year 1991 based on the adjustments made for maximum CHAMPUS prevailing charge levels through 1990 and the application of paragraph G.1.e. of this section for 1991.

(2) The adjustment to calendar year 1991 of the product of paragraph G.1.f.(1) of this section shall be as follows:

(a) For procedures other than those described in paragraph G.1.f.(2)(b) of this section, the adjustment to 1991 shall be on the same basis as that provided under paragraph G.1.e. of this section.

(b) For any procedure that was considered an overpriced procedure for purposes of the 1991 prevailing charge levels under paragraph G.1.e. of this section for which the resulting 1991 prevailing charge level was less than 150 percent of the Medicare converted relative value unit, the adjustment to 1991 for purposes of the special transition rule for 1992 shall be as if the procedure had been treated under paragraph G.1.e.(2)(b) of this section for purposes of the 1991 prevailing charge level.

g. Adjustments and procedural rules.

(1) The Director, OCHAMPUS may make adjustments to the appropriate charge levels calculated pursuant to paragraphs G.1.c. and G.1.e. of this section to correct any anomalies resulting from data or statistical factors, significant differences between Medicare-relevant information and CHAMPUS-relevant considerations or other special factors that fairness requires be specially recognized. However, no such adjustment may result in reducing an appropriate charge level.

(2) The Director, OCHAMPUS will issue procedural instructions for administration of the allowable charge method.

h. Clinical laboratory services. The allowable charge for clinical diagnostic laboratory test services shall be calculated in the same manner as allowable charges for other individual health care providers are calculated pursuant to paragraphs G.1.a. through G.1.d. of this Chapter, with the following exceptions and clarifications.

(1) The calculation of national prevailing charge levels, national appropriate charge levels and national CMACs for laboratory services shall begin in calendar year 1993. For purposes of the 1993 calculation, the prior year year's national appropriate charge level or national prevailing charge level shall be the level that does not exceed the amount equivalent to the 80th percentile of billed charges made for similar services during the period July 1, 1991, through June 30, 1992 (referred to in this paragraph G.1.h. of this Chapter as the "base period").

(2) For purposes of comparison to Medicare allowable payment amounts pursuant to paragraph G.1.c. of this Chapter, the Medicare national laboratory payment limitation amounts shall be used.

(3) For purposes of establishing laboratory service local CMACs pursuant to paragraph G.1.d. of this Chapter, the adjustment factor shall equal the ratio of the local average charge (standardized for the distribution clinical laboratory services) to the national average charge for all clinical laboratory services during the base period.

(4) For purposes of a special locality-based phase-in provision similar to that estasblished by paragraph G.1.d.(2) of this Chapter, the CMAC in a locality will not be less than 85 percent of the maximum charge level in effect for that locality during the base period.

i. The allowable charge for physician assistant services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant services performed as an assistant-at- surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of Chapter 4 C.3.c. of this Part. Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

j. A charge that exceeds the CHAMPUS Maximum Allowable charge can be determined to be allowable only when unusual circumstances or medical complications justify the higher charge. The allowable charge may not exceed the billed charge under any circumstances.

2. All-inclusive rate. Claims from individual health-care professional providers for services rendered to CHAMPUS beneficiaries residing in an RTC that is either being reimbursed on an all-inclusive per diem rate, or is billing an all-inclusive per diem rate, shall be denied; with the exception of

independent health-care professionals providing geographically distant family therapy to a family member residing a minimum of 250 miles from the RTC or covered medical services related to a nonmental health condition rendered outside the RTC. Reimbursement for individual professional services is included in the rate paid the institutional provider.

3. Alternative method. The Director, OCHAMPUS, or a designee, may, subject to the approval of the ASD(HA), establish an alternative method of reimbursement designed to produce reasonable control over health care costs and to ensure a high level of acceptance of the CHAMPUS-determined charge by the individual health-care professionals or other noninstitutional health-care providers furnishing services and supplies to CHAMPUS beneficiaries. Alternative methods may not result in reimbursement greater than the allowable charge method above.

H. REIMBURSEMENT UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The Military-Civilian Health Services Partnership Program, as authorized by Section 1096, Chapter 55, Title 10, provides for the sharing of staff, equipment, and resources between the civilian and military health care system

in order to achieve more effective, efficient, or economical health care for authorized beneficiaries. Military treatment facility commanders, based upon the authority provided by their respective Surgeons General of the military departments, are responsible for entering into individual partnership agreements only when they have determined specifically that use of the Partnership Program is more economical overall to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS Program. (See Section P. of Chapter 1, for general requirements of the Partnership Program.)

1. Reimbursement of institutional health care providers. Reimbursement of institutional health care providers under the Partnership Program shall be on the same basis as non-Partnership providers.

2. Reimbursement of individual health-care professionals and other non-institutional health care providers. Reimbursement of individual health care professional and other non-institutional health care providers shall be on the same basis as non-Partnership providers as detailed in Section G. of this chapter.

I. ACCOMMODATION OF DISCOUNTS UNDER PROVIDER REIMBURSEMENT METHODS

1. General rule. The Director, OCHAMPUS (or designee) has authority to reimburse a provider at an amount below the amount usually paid pursuant to this chapter when, under a program approved by the Director, the provider has agreed to the lower amount.

2. Special applications. The following are examples of applications of the general rule; they are not all inclusive.

a. In the case of individual health care professionals and other noninstitutional providers, if the discounted fee is below the provider's normal billed charge and the prevailing charge level (see section G. of this chapter), the discounted fee shall be the provider's actual billed charge and the CHAMPUS allowable charge.

b. In the case of institutional providers normally paid on the basis of a pre-set amount (such as DRG-based amount under subsection A.1. of this chapter or per-diem amount under subsection A.2. of this chapter), if the discount rate is lower than the pre-set rate, the discounted rate shall be the CHAMPUS-determined allowable cost. This is an exception to the usual rule that the pre-set rate is paid regardless of the institutional provider's billed charges or other factors.

3. Procedures.

a. This section only applies when both the provider and the Director have agreed to the discounted payment rate. The Director's agreement may be in the context of approval of a program that allows for such discounts.

b. The Director of OCHAMPUS may establish uniform terms, conditions and limitations for this payment method in order to avoid administrative complexity.

J. OUTSIDE THE UNITED STATES

The Director, OCHAMPUS, or a designee, shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPUS benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States.

K. IMPLEMENTING INSTRUCTIONS

The Director, OCHAMPUS, or a designee, shall issue CHAMPUS policies, instructions, procedures, and guidelines, as may be necessary to implement the intent of this chapter.

CHAPTER 15

QUALITY AND UTILIZATION PEER REVIEW ORGANIZATION PROGRAM

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#First Amendment (Ch 6, 6/24/94)

CHAPTER 15
QUALTIY AND UTILIZATION REVIEW PEER REVIEW ORGANIZATION PROGRAM

A. GENERAL

1. Purpose. The purpose of this chapter is to establish rules and procedures for the CHAMPUS Quality and Utilization Review Peer Review Organization program.

2. Applicability of program. All claims submitted for health services under CHAMPUS are subject to review for quality of care and appropriate utilization. The Director, OCHAMPUS shall establish generally accepted standards, norms and criteria as are necessary for this program of utilization and quality review. These standards, norms and criteria shall include, but not be limited to, need for inpatient admission or inpatient or outpatient service, length of inpatient stay, intensity of care, appropriateness of treatment, and level of institutional care required. The Director, OCHAMPUS may issue implementing instructions, procedures and guidelines for retrospective, concurrent and prospective review.

3. Contractor implementation. The CHAMPUS Quality and Utilization Review Peer Review Organization program may be implemented through contracts administered by the Director, OCHAMPUS. These contractors may include contractors that have exclusive functions in the area of utilization and quality review, fiscal intermediary contractors (which perform these functions along with a broad range of administrative services), and managed care contractors (which perform a range of functions concerning management of the delivery and financing of health care services under CHAMPUS). Regardless of the contractors involved, utilization and quality review activities follow the same standards, rules and procedures set forth in this chapter, unless otherwise specifically provided in this chapter or elsewhere in this Regulation.

4. Medical issues affected. The CHAMPUS Quality and Utilization Review Peer Review Organization program is distinguishable in purpose and impact from other activities relating to the administration and management of CHAMPUS in that the Peer Review Organization program is concerned primarily with medical judgements regarding the quality and appropriateness of health care services. Issues regarding such matters as benefit limitations are similar, but, if not determined on the basis of medical judgements, are governed by CHAMPUS rules and procedures other than those provided in this chapter. (See, for example, Chapter 7 regarding claims submission, review and payment.) Based on this

purpose, a major attribute of the Peer Review Organization program is that medical judgements are made by (directly or pursuant to guidelines and subject to direct review) reviewers who are peers of the health care providers providing the services under review.

5. Provider responsibilities. Because of the dominance of medical judgements in the quality and utilization review program, principal responsibility for complying with program rules and procedures rests with health care providers. For this reason, there are limitations, set forth in this chapter and in paragraph H, Chapter 4, on the extent to which beneficiaries may be held financially liable for health care services not provided in conformity with rules and procedures of the quality and utilization review program concerning medical necessity of care.

6. Medicare rules used as model. The CHAMPUS Quality and Utilization Review Peer Review Organization program, based on specific statutory authority, follows many of the quality and utilization review requirements and procedures in effect for the Medicare Peer Review Organization program, subject to adaptations appropriate for the CHAMPUS program.

B. OBJECTIVES AND GENERAL REQUIREMENTS OF REVIEW SYSTEM.

1. In general. Broadly, the program of quality and utilization review has as its objective to review the quality, completeness and adequacy of care provided, as well as its necessity, appropriateness and reasonableness.

2. Payment exclusion for services provided contrary to utilization and quality standards.

a. In any case in which health care services are provided in a manner determined to be contrary to quality or necessity standards established under the quality and utilization review program, payment may be wholly or partially excluded.

b. In any case in which payment is excluded pursuant to paragraph B.2.a. of this chapter, the patient (or the patient's family) may not be billed for the excluded services.

c. Limited exceptions and other special provisions pertaining to the requirements established in paragraphs B.2.a. and b. of this chapter, are set forth in Chapter 4, paragraph H.

3. Review of services covered by DRG-based payment system. Application of these objectives in the context of hospital services covered by the DRG-based payment system also includes a validation of diagnosis and procedural information that determines CHAMPUS reimbursement, and a review of the necessity and appropriateness of care for which payment is sought on an outlier basis.

4. Preauthorization and other utilization review procedures.

a. In general. All health care services for which payment is sought under CHAMPUS are subject to review for appropriateness of utilization. The

procedures for this review may be prospective (before the care is provided), concurrent (while the care is in process), or retrospective (after the care has been provided). Regardless of the procedures of this utilization review, the same generally accepted standards, norms and criteria for evaluating the necessity, appropriateness and reasonableness of the care involved shall apply. The Director, OCHAMPUS shall establish procedures for conducting reviews, including identification of types of health care services for which preauthorization or concurrent review shall be required. Preauthorization or concurrent review may be required for any categories of health care services. Except where required by law, the categories of health care services for which preauthorization or concurrent review is required may vary in different geographical locations or for different types of providers.

b. Preauthorization procedures. With respect to categories of health care (inpatient or outpatient) for which preauthorization is required, the following procedures shall apply:

(1) The requirement for preauthorization shall be widely publicized to beneficiaries and providers.

(2) All requests for preauthorization shall be responded to in writing. Notification of approval or denial shall be sent to the beneficiary. Approvals shall specify the health care services and supplies approved and identify any special limits or further requirements applicable to the particular case.

(3) An approved preauthorization shall state the number of days, appropriate for the type of care involved, for which it is valid. In general, preauthorizations will be valid for 30 days. If the services or supplies are not obtained within the number of days specified, a new preauthorization request is required.

c. Payment reduction for noncompliance with required utilization review procedures.

(1) Paragraph B.4.c. of this chapter applies to any case in which:

(a) A provider was required to obtain preauthorization or continued stay (in connection with required concurrent review procedures) approval.

(b) The provider failed to obtain the necessary approval; and

(c) The health care services have not been disallowed on the basis of necessity, appropriateness or reasonableness.

In such a case, reimbursement will be reduced, unless such reduction is waived based on special circumstances.

(2) In a case described in paragraph B.4.c.(1) of this chapter, reimbursement will be reduced, unless such reduction is waived based on special circumstances. The amount of this reduction shall be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained, but was not obtained. In the case of hospital admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100 percent) of the total reimbursement equal to the number of days of care provided without preauthorization approval, divided by the total length of stay for the admission. In the case of institutional payments based on per diem payments, the reduction shall be taken only against the days of care provided without preauthorization approval. For care for which payment is on a per service basis, the reduction shall be taken only against the amount that relates to the services provided without preauthorization approval. Unless otherwise specifically provided under procedures issued by the Director, OCHAMPUS, the effective date of any preauthorization approval shall be the date on which a properly submitted request was received by the review organization designated for that purpose.

(3) The payment reduction set forth in paragraph B.4.c.(2) of this chapter may be waived by the Director, OCHAMPUS when the provider could not reasonably have been expected to know of the preauthorization requirement or some other special circumstance justifies the waiver.

(4) Services for which payment is disallowed under paragraph B.4.c. of this chapter may not be billed to the patient (or the patient's family).

C. HOSPITAL COOPERATION

All hospitals which participate in CHAMPUS and submit CHAMPUS claims are required to provide all information necessary for CHAMPUS to properly process the claims. In order for CHAMPUS to be assured that services for which claims are submitted meet quality of care standards, hospitals are required to provide the Peer Review Organization (PRO) responsible for quality review with all the information, within timeframes to be established by OCHAMPUS, necessary to perform the review functions required by this chapter. Additionally, all participating hospitals shall provide CHAMPUS beneficiaries, upon admission, with information about the admission and quality review system including their appeal rights. A hospital which does not cooperate in this activity shall be subject to termination as a CHAMPUS-authorized provider.

1. Documentation that the beneficiary has received the required information about the CHAMPUS PRO program must be maintained in the same manner as is the notice required for the Medicare program by 42 CFR 466.78(b).

2. The physician attestation and physician acknowledgement required for Medicare under 42 CFR 412.40 and 412.46 are also required for CHAMPUS as a condition for payment and may be satisfied by the same statements as required for Medicare, with substitution or addition of "CHAMPUS" when the word "Medicare" is used.

3. Participating hospitals must execute a memorandum of understanding with the PRO providing appropriate procedures for implementation of the PRO program.

4. Participating hospitals may not charge a CHAMPUS beneficiary for inpatient hospital services excluded on the basis of Chapter 4, section G.1. (not medically necessary), section G.3. (inappropriate level), or section G.7. (custodial care) unless all of the conditions established by 42 CFR 412.42(c) with respect to Medicare beneficiaries have been met with respect to the CHAMPUS beneficiary. In such cases in which the patient requests a PRO review while the patient is still an inpatient in the hospital, the hospital shall provide to the PRO the records required for the review by the close of business of the day the patient requests review, if such request was made before noon. If the hospital fails to provide the records by the close of business, that day and any subsequent working day during which the hospital continues to fail to provide the records shall not be counted for purposes of the two-day period of 42 CFR 412.42(c)(3)(ii).

5. With respect to cases subject to preadmission review, the provisions of 42 C.F.R. 466.78(b)(5)-(b)(7) shall apply to CHAMPUS cases as those provisions apply to Medicare cases.

D. AREAS OF REVIEW

1. Admissions. The following areas shall be subject to review to determine whether inpatient care was medically appropriate and necessary, was delivered in the most appropriate setting and met acceptable standards of quality. This review may include preadmission or prepayment review when appropriate.

a. Transfers of CHAMPUS beneficiaries from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system to another hospital or hospital unit.

b. CHAMPUS admissions to a hospital or hospital unit subject to the CHAMPUS DRG-based payment system which occur within a certain period (specified by OCHAMPUS) of discharge from a hospital or hospital unit subject to the CHAMPUS DRG-based payment system.

c. A random sample of other CHAMPUS admissions for each hospital subject to the CHAMPUS DRG-based payment system.

d. CHAMPUS admissions in any DRGs which have been specifically identified by OCHAMPUS for review or which are under review for any other reason.

2. DRG validation. The review organization responsible for quality of care reviews shall be responsible for ensuring that the diagnostic and procedural information reported by hospitals on CHAMPUS claims which is used by the fiscal intermediary to assign claims to DRGs is correct and matches the information contained in the medical records. In order to accomplish this, the following review activities shall be done.

a. Perform DRG validation reviews of each case under review.

b. Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG.

c. Review for physician certification as to the major diagnoses and procedures and the physician's acknowledgment of annual receipt of the penalty statement as contained in the Medicare regulations at 42 CFR 412.40 and 412.46.

d. Review of a sample of claims for each hospital reimbursed under the CHAMPUS DRG-based payment system. Sample size shall be determined based upon the volume of claims submitted.

3. Outlier review. Claims which qualify for additional payment as a long-stay outlier or as a cost-outlier shall be subject to review to ensure that the additional days or costs were medically necessary and appropriate and met all other requirements for CHAMPUS coverage. In addition, claims which qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

4. Procedure review. Claims for procedures identified by OCHAMPUS as subject to a pattern of abuse shall be the subject of intensified quality assurance review.

5. Other review. Any other cases or types of cases identified by OCHAMPUS shall be subject to focused review.

E. ACTIONS AS A RESULT OF REVIEW

1. Findings related to individual claims. If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admissions of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the PRO, in conjunction with the fiscal intermediary, shall, as appropriate:

a. Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination.

b. Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

c. Advise the provider and beneficiary of appeal rights, as required by Chapter 10 of this Regulation.

d. Notify OCHAMPUS of all such actions.

2. Findings related to a pattern of inappropriate practices. In all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the CHAMPUS DRG-based payment system is identified, OCHAMPUS shall be notified of the hospital and practice involved.

3. Revision of coding relating to DRG validation. The following provisions apply in connection with the DRG validation process set forth in subsection D.2. of this chapter.

a. If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the CHAMPUS claim will be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.

b. If the information attested to by the physician as stipulated under subsection E.2. of this chapter is found not to be correct, the PRO will change the coding and assign the appropriate DRG on the basis of the changed coding.

F. SPECIAL PROCEDURES IN CONNECTION WITH CERTAIN TYPES OF HEALTH CARE SERVICES OR CERTAIN TYPES OF REVIEW ACTIVITIES.

1. In general. Many provisions of this chapter are directed to the context of services covered by the CHAMPUS DRG-based payment system. This section, however, is also applicable to other services. In addition, many provisions of this chapter relate to the context of peer review activities performed by Peer Review Organizations whose sole functions for CHAMPUS relate to the Quality and Utilization Review Peer Review Organization program. However, it also applies to review activities conducted by contractors who have responsibilities broader than those related to the quality and utilization review program. Paragraph F of this chapter authorizes certain special procedures that will apply in connection with such services and such review activities.

2. Services not covered by the DRG-based payment system. In implementing the quality and utilization review program in the context of services not covered by the DRG-based payment system, the Director, OCHAMPUS may establish procedures, appropriate to the types of services being reviewed, substantively comparable to services covered by the DRG-based payment system regarding obligations of providers to cooperate in the quality and utilization review program, authority to require appropriate corrective actions and other procedures. The Director, OCHAMPUS may also establish such special, substantively comparable procedures in connection with review of health care services which, although covered by the DRG-based payment method, are also affected by some other special circumstances concerning payment method, nature of care, or other potential utilization or quality issue.

3. Peer review activities by contractors also performing other administration or management functions.

a. Sole-function PRO versus multi-function PRO. In all cases, peer review activities under the Quality and Utilization Review Peer Review

Organization program are carried out by physicians and other qualified health care professionals, usually under contract with OCHAMPUS. In some cases, the Peer Review Organization contractor's only functions are pursuant to the quality and utilization review program. In paragraph F.3, of this chapter, this type of contractor is referred to as a "sole function PRO." In other cases, the Peer Review Organization contractor is also performing other functions in connection with the administration and management of CHAMPUS. In paragraph F.3, of this chapter, this type of contractor is referred to as a "multi-function PRO." As an example of the latter type, managed care contractors may perform a wide range of functions regarding management of the delivery and financing of health care services under CHAMPUS, including but not limited to functions under the Quality and Utilization Review Peer Review Organization program.

b. Special rules and procedures. With respect to multi-function PROs, the Director, OCHAMPUS may establish special procedures to assure the independence of the Quality and Utilization Review Peer Review Organization program and otherwise advance the objectives of the program. These special rules and procedures include, but are not limited to, the following:

(1) A reconsidered determination that would be final in cases involving sole-function PROs under paragraph I.2. of this chapter will not be final in connection with multi-function PROs. Rather, in such cases (other than any case which is appealable under paragraph I.3. of this chapter), an opportunity for a second reconsideration shall be provided. The second reconsideration will be provided by OCHAMPUS or another contractor independent of the multi-function PRO that performed the review. The second reconsideration may not be further appealed by the provider.

(2) Procedures established by paragraphs G through M of this chapter shall not apply to any action of a multi-function PRO (or employee or other person or entity affiliated with the PRO) carried out in performance of functions other than functions under this section.

G. PROCEDURES REGARDING INITIAL DETERMINATIONS

The CHAMPUS PROs shall establish and follow procedures for initial determinations that are substantively the same or comparable to the procedures applicable to Medicare under 42 CFR 466.83 to 466.104. In addition, these procedures shall provide that a PRO's determination that an admission is medically necessary is not a guarantee of payment by CHAMPUS; normal CHAMPUS benefit and procedural coverage requirements must also be applied.

H. PROCEDURES REGARDING RECONSIDERATIONS

The CHAMPUS PROs shall establish and follow procedures for reconsiderations that are substantively the same or comparable to the procedures applicable to

reconsiderations under Medicare pursuant to 42 CFR 473.15 to 473.34, except that the time limit for requesting reconsideration (see 42 CFR 473.20(a)(1)) shall be 90 days. A PRO reconsidered determination is final and binding upon all parties to the reconsideration except to the extent of any further appeal pursuant to section I. of this chapter.

I. APPEALS AND HEARINGS

1. Beneficiaries may appeal a PRO reconsideration determination to OCHAMPUS and obtain a hearing on such appeal to the extent allowed and under the procedures set forth in Chapter 10, section D.

2. Except as provided in subsection I.3., a PRO reconsidered determination may not be further appealed by a provider.

3. A provider may appeal a PRO reconsideration determination to OCHAMPUS and obtain a hearing on such appeal to the extent allowed under the procedures set forth in Chapter 10, section D. if it is a determination pursuant to Chapter 4, section H. that the provider knew or could reasonably have been expected to know that the services were excludable.

4. For purposes of the hearing process, a PRO reconsidered determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10, unless revised at the initiative of the Director, OCHAMPUS prior to a hearing on the appeal, in which case the revised determination shall be considered as the procedural equivalent of a formal review determination under Chapter 10.

5. The provisions of Chapter 10, section E. concerning final action shall apply to hearings cases.

J. ACQUISITION, PROTECTION AND DISCLOSURE OF PEER REVIEW INFORMATION

The provisions of 42 CFR Part 476, except section 476.108, shall be applicable to the CHAMPUS PRO program as they are to the Medicare PRO program.

K. LIMITED IMMUNITY FROM LIABILITY FOR PARTICIPANTS IN PRO PROGRAM

The provisions of section 1157 of the Social Security Act (42 U.S.C. 1320c-6) are applicable to the CHAMPUS PRO program in the same manner as they apply to the Medicare PRO program. Section 1102(g) of title 10, United States Code also applies to the CHAMPUS PRO program.

L. ADDITIONAL PROVISION REGARDING CONFIDENTIALITY OF RECORDS

1. General rule. The provisions of 10 U.S.C. 1102 regarding the confidentiality of medical quality assurance records shall apply to the activities of the CHAMPUS PRO program as they do to the activities of the external civilian PRO program that reviews medical care provided in military hospitals.

2. Specific applications.

a. Records concerning PRO deliberations are generally nondisclosable quality assurance records under 10 U.S.C. 1102.

b. Initial denial determinations by PROs pursuant to section G. of this chapter (concerning medical necessity determinations, DRG validation actions, etc.) and subsequent decisions regarding those determinations are not nondisclosable quality assurance records under 10 U.S.C. 1102.

c. Information the subject of mandatory PRO disclosure under 42 CFR Part 476 is not a nondisclosable quality assurance record under 10 U.S.C. 1102.

M. OBLIGATIONS, SANCTIONS AND PROCEDURES

1. The provisions of 42 CFR 1004.1 - 1004.80 shall apply to the CHAMPUS PRO program as they do the Medicare PRO program, except that the functions specified in those sections for the Office of Inspector General of the Department of Health and Human Services shall be the responsibility of OCHAMPUS.

2. The provisions of 42 U.S.C. section 1395ww(f)(2) concerning circumvention by any hospital of the applicable payment methods for inpatient services shall apply to CHAMPUS payment methods as they do to Medicare payment methods.

3. The Director, or a designee, of CHAMPUS shall determine whether to impose a sanction pursuant to subsections M.1. and M.2. of this chapter. Providers may appeal adverse sanctions decisions under the procedures set forth in Chapter 10, section D.

CHAPTER 16

SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

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#Fitst Amendment (Ch 6, 6/24/94)

CHAPTER 16
SUPPLEMENTAL HEALTH CARE PROGRAM FOR ACTIVE DUTY MEMBERS

A. Purpose and applicability.

1. The purpose of this chapter is to implement, with respect to health care services provided under the supplemental health care program for active duty members of the uniformed services, the provision of 10 U.S.C. 1074(c). This section of law authorizes DoD to establish for the supplemental care program the same payment rules, subject to appropriate modifications, as apply under CHAMPUS.

2. This chapter applies to the program, known as the supplemental care program, which provides for the payment by the uniformed services to private sector health care providers for health care services provided to active duty members of the uniformed services. Although not part of CHAMPUS, the supplemental care program is similar to CHAMPUS in that it is a program for the uniformed services to purchase civilian health care services for active duty members. For this reason, the Director, OCHAMPUS, assists the uniformed services in the administration of the supplemental care program.

3. This chapter applies to all health care services covered by CHAMPUS. For purposes of this chapter, health care services ordered by a military treatment facility (MFT) provider for an MTF patient (who is not an active duty member) for whom the MTF provider maintains responsibility are also covered by the supplemental care program and subject to the requirements of this chapter.

B. Obligation of providers concerning payment for supplemental health care for active duty members.

1. Hospitals covered by DRG-based payment system. For a hospital covered by the CHAMPUS DRG-based payment system to maintain its status as an authorized provider for CHAMPUS pursuant to Chapter 6, that hospital must also be a participating provider for purposes of the supplemental care program. As a participating provider, each hospital must accept the DRG-based payment system amount determined pursuant to Chapter 14 as payment in full for the hospital services covered by the system. The failure of any hospital to comply with this obligation subjects that hospital to exclusion as a CHAMPUS-authorized provider.

2. Other participating providers. For any institutional or individual provider, other than those described in paragraph B.1 of this Chapter that is a participating provider, the provider must also be a participating provider for purposes of the supplemental care program. The provider must accept the CHAMPUS allowable amount determined pursuant to Chapter 14 as payment in full for the hospital services covered by the system. The failure of any provider to comply with this obligation subjects the provider to exclusion as a participating provider.

#First Amendment (Ch 6, 6/24/94)

C. General rule for payment and administration. Subject to the special rules and procedures in paragraph D. of this chapter, and the waiver authority in paragraph E. of this chapter, as a general rule the provisions of Chapter 14 shall govern payment and administration of claims under the supplemental care program as they do claims under CHAMPUS. To the extent necessary to interpret or implement the provisions of Chapter 14, related provisions of DoD 6010.8-R shall also be applicable.

D. Special rules and procedures. As exceptions to the general rule in paragraph C. of this chapter, the special rules and procedures in this chapter shall govern payment and administration of claims under the supplemental care program. These special rules and procedures are subject to the waiver authority of paragraph E. of this chapter.

1. There is no patient cost sharing under the supplemental care program. All amounts due to be paid to the provider shall be paid by the program.

2. Preauthorization by the uniformed services of each service, except for services in cases of medical emergency (for which the definition in Chapter 2 shall apply), is required for the supplemental care program. It is the responsibility of the active duty members to obtain preauthorization for each service. With respect to each emergency inpatient admission, after such time as the emergency condition is addressed, authorization for any proposed continued stay must be obtained within two working days of admission.

3. With respect to the filing of claims and similar administrative matters for which DoD 6010.8-R refers to activities of the CHAMPUS fiscal intermediaries, for purposes of the supplemental care program, responsibilities for claims processing, payment and some other administrative matters may be assigned by the Director, OCHAMPUS to the same fiscal intermediaries, other contractor, or to the nearest military medical treatment facility or medical claims office.

4. The annual cost pass-throughs for capital and direct medical education costs that are available under the CHAMPUS DRG-based payment system are also available, upon request, under the supplemental care program. To obtain payment include the number of active duty bed days as a separate line item on the annual request to the CHAMPUS fiscal intermediaries.

5 For providers other than participating providers, the Director, OCHAMPUS may authorize payment in excess of CHAMPUS allowable amounts. No provider may bill an active duty member any amount in excess of the CHAMPUS allowable amount.

E. Waiver authority. With the exception of statutory requirements, any restrictions or limitations pursuant to the general rule in paragraph C of this chapter, and special rules and procedures in paragraph D of this chapter may be waived by the Director, OCHAMPUS at the request of an authorized official of the uniformed service concerned, based on a determination that such waiver is necessary to assure adequate availability of health care services to active duty members.

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F. Authorities.

1. The Uniformed Services may establish additional procedures, consistent with this chapter, for the effective administration of the supplemental care program in their respective services.

2. The Assistant Secretary of Defense for Health Affairs is responsible for the overall policy direction of the supplemental care program and the administration of this chapter.

3. The Director, OCHAMPUS shall issue procedural requirements for the implementation of this Chapter, including the requirement for claims submission similar to those established by Chapter 17.